

## 2007 Physician Voluntary Reporting Program (PVRP) Measure Specifications

### Measure #1: Hemoglobin A1c poor control in patients with Type 1 or 2 diabetes mellitus

#### Numerator

Patients with most recent A1c level > 9.0%

#### Numerator Coding:

● **G8015:** Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented as greater than 9% **OR**

**CPT II 3046F:** Most recent hemoglobin A1c level > 9.0%

● **G8016:** Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented as less than or equal to 9% **OR**

**CPT II 3044F:** Most recent hemoglobin A1c level < 7.0%

**OR**

**CPT II 3045F:** Most recent hemoglobin A1c level 7.0% to 9.0%

● **G8017:** Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure **OR**

**Append a modifier (1P, 2P or 3P) to the following CPT Category II code(s) to report patients with documented circumstances that meet the denominator exclusion criteria:**

- **3044F:** Most recent hemoglobin A1c level < 7.0%
- **3045F:** Most recent hemoglobin A1c level 7.0% to 9.0%
- **3046F:** Most recent hemoglobin A1c level > 9.0%

● **G8018:** Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (12 months)

#### Denominator

Patients aged 18-75 with the diagnosis of diabetes

#### Denominator Coding:

ICD-9-CM codes 250.00-250.93 (DM), 357.2 (polyneuropathy in DM), 362.01-362.07 (DM retinopathy), 366.41 (DM cataract), 648.00, 648.01, 648.02, 648.04 (DM in pregnancy, not gestational)

**AND**

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians providing services for the primary management of diabetes mellitus will submit this measure. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes are: modifier 1P- medical reasons, 2P- patient reasons, and 3P- system reasons.

Rationale:

Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.<sup>1,,23</sup>

Clinical Recommendation Statements:

A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals.<sup>4</sup> (AACE/ACE)

The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values  $\leq 6.5\%$ . (AACE/ACE)

Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of evidence: E)<sup>5</sup> (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c  $< 7\%$ . (Level of evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1C of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered.<sup>6</sup> (AGS)

## Measure #2: Low-density lipoprotein control in Type 1 or 2 diabetes mellitus

### Numerator:

Patients with most recent LDL-C <100 mg/dL

### Numerator Coding:

● **G8020:** Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl **OR**

**CPT II 3048F:** Most recent LDL-C < 100 mg/dL

● **G8019:** Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl **OR**

**CPT II 3049F:** Most recent LDL-C 100-129 mg/dL **OR**

**CPT II 3050F:** Most recent LDL-C > 130 mg/dL

● **G8021:** Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure **OR**

**Append a modifier (1P, 2P, or 3P) to one of the following CPT Category II codes to report patients with documented circumstances that meet the denominator exclusion criteria:**

- **3048F:** Most recent LDL-C < 100 mg/dL
- **3049F:** Most recent LDL-C 100-129 mg/dL
- **3050F:** Most recent LDL-C > 130 mg/dL

● **G8022:** Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)

### Denominator:

Patients aged 18-75 years with the diagnosis of diabetes

### Denominator Coding:

ICD-9-CM codes 250.00-250.93 (DM), 357.2 (polyneuropathy in DM), 362.01-362.07 (DM retinopathy), 366.41 (DM cataract), 648.00, 648.01, 648.02, 648.04 (DM in pregnancy, not gestational)

### AND

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

### Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians providing services for the primary management of diabetes mellitus will submit this measure. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the appropriate CPT Category II code OR the CPT Category II code WITH the exclusion modifier code. The exclusion modifier codes are: modifier 1P- medical reasons, 2P- patient reasons, and 3P- system reasons.

Rationale:

Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.<sup>8</sup>

Clinical Recommendation Statements:

A fasting lipid profile should be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module.<sup>4,9</sup> (AACE/ACE)

A fasting lipid profile should be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years. (Level of evidence: E)<sup>5</sup> (ADA)

Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy. Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. (Level of evidence: A)

Lipid-lowering therapy should be used for secondary prevention of cardiovascular mortality and morbidity for all patients with known coronary artery disease and type 2 diabetes. (ACP)

Statins should be used for primary prevention against macrovascular complications in patients with type 2 diabetes and other cardiovascular risk factors.

Once lipid-lowering therapy is initiated, patients with type 2 diabetes mellitus should be taking at least moderate doses of a statin.<sup>10</sup>

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias (AGS)

**Measure #3: High blood pressure control in Type 1 or 2 diabetes mellitus**

Numerator:

Patients whose most recent blood pressure <140/80 mm Hg

**Numerator Coding:**

• **G8024:** Diabetic patient with most recent blood pressure (within the last 12 months) documented less than 140 systolic and less than 80 diastolic **OR**

**CPT II 3074F:** Most recent systolic blood pressure < 130 mm Hg **AND**

**CPT II 3078F:** Most recent diastolic blood pressure < 80 mm Hg

**OR**

**CPT II 3075F:** Most recent systolic blood pressure 130 to 139 mm Hg **AND**

**CPT II 3078F:** Most recent diastolic blood pressure < 80 mm Hg

• **G8023:** Diabetic patient with most recent blood pressure (within the last 12 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic **OR**

**CPT II 3077F:** Most recent systolic blood pressure > 140 mm Hg **AND**

**CPT II 3079F:** Most recent diastolic blood pressure 80-89 mm Hg

**OR**

**CPT II 3077F:** Most recent systolic blood pressure > 140 mm Hg **AND**

**CPT II 3080F:** Most recent diastolic blood pressure > 90 mm Hg

• **G8025:** Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure **OR**

**Append a modifier (1P, 2P, or 3P) to one of the following combinations of CPT Category II codes to report patients with documented circumstances that meet the denominator exclusion criteria:**

• **3074F:** Most recent systolic blood pressure < 130 mm Hg **AND**

**3078F:** Most recent diastolic blood pressure < 80 mm Hg

**OR**

• **3075F:** Most recent systolic blood pressure 130 to 139 mm Hg **AND**

**3078F:** Most recent diastolic blood pressure < 80 mm Hg

**OR**

• **3077F:** Most recent systolic blood pressure > 140 mm Hg **AND**

**3079F:** Most recent diastolic blood pressure 80-89 mm Hg

**OR**

• **3077F:** Most recent systolic blood pressure > 140 mm Hg **AND**

**3080F:** Most recent diastolic blood pressure > 90 mm Hg

• **G8026:** Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 12 months)

Denominator:

Patients aged 18-75 years with the diagnosis of diabetes

Denominator Coding:

ICD-9-CM codes 250.00-250.93 (DM), 357.2 (polyneuropathy in DM), 362.01-362.07 (DM retinopathy), 366.41 (DM cataract), 648.00, 648.01, 648.02, 648.04 (DM in pregnancy, not gestational)

AND

E&M visit: 99201-99205, 99211-99215, (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians providing services for the primary management of diabetes mellitus will submit this measure. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes are: modifier 1P- medical reasons, 2P- patient reasons, and 3P- system reasons.

Rationale:

Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.<sup>11</sup>

Clinical Recommendation Statements:

Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. (AACE/ACE)

Blood pressure control must be a priority in the management of persons with hypertension and type 2 diabetes.<sup>12</sup> (ACP)

Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure >130 mmHg or diastolic >80 mmHg should have blood pressure confirmed on a separate day. Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy. (Level of Evidence: E)<sup>13</sup> (ADA)

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. (AGS)

Measurement of blood pressure in the standing position is indicated periodically, especially in those at risk for postural hypotension. At least two measurements should be made and the average recorded. After BP is at goal and stable, followup visits can usually be at 3- to 6-month intervals. Comorbidities such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. (JNC)

All individuals should be evaluated during health encounters to determine whether they are at increased risk of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement. (NKF)

#### **\*Measure #4: Falls: Screening for Fall Risk**

##### Description

Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

##### Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). It is anticipated that clinicians providing primary care for the patient will submit this measure.

##### **This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

##### Numerator

Patients who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti).

##### **Numerator Coding:**

##### **Screening for Fall Risk (2 or more falls in the past year or any fall with injury in the past year) Performed**

**G8270:** Patient documented to have received screening for fall risk (2 or more falls in the past year or any fall with injury in the past year)

**OR**

- **CPT II XXXXF:** Patient screened for fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

**OR**

- **CPT II XXXXF:** Patient screened for fall risk; documentation of no falls in the past year or only one fall without injury in the past year

##### **Screening for Fall Risk Not Performed**



- **G8271:** Patients with no documentation of screening for fall risk (2 or more falls in the past year or any fall with injury in the past year)

#### **Screening for Fall Risk not Performed by Reason of Appropriate Exclusion**

- **G8272:** Clinician documentation that patient was not an eligible candidate for fall risk screening

#### **OR**

Append a modifier (1P) to the CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.

- 1P: Documentation of medical reason(s) for not screening for fall risk (eg, patient is not ambulatory)

#### **Clinician has not Provided Care**

**G8273:** Clinician has not provided care for the patient for the required time to screen for fall risk

#### Denominator:

All patients aged 65 years and older

#### Denominator Coding:

Evaluation and Management/Office Visit Codes are required for denominator inclusion to identify patients aged 65 years and older who were seen by the physician at least twice within 12 months.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354-99355, 99387, 99397, 99401-99404

#### Rationale

Patients may not volunteer information regarding falls.

#### Clinical Recommendation Statements

All older persons who are under the care of a health professional (or their caregivers) should be asked at least once a year about falls. (AGS/BGS/AAOS)

Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should have a fall evaluation performed. This evaluation should be performed by a clinician with appropriate skills and experience, which may necessitate referral to a specialist (e.g., geriatrician). (AGS/BGS/AAOS)

Older people in contact with health care professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the falls. (NICE) (Grade C)

Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (NICE) (Grade C)

**▲ Measure #5: Heart Failure: Angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) therapy for left ventricular systolic dysfunction (LVSD) for patients with heart failure**

Numerator:

Patients who were prescribed ACE inhibitor or ARB therapy

**Numerator Coding:**

● **G8027:** Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

**OR**

**CPT Cat II 4009F:** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

**AND**

**CPT II 3021F:** Left ventricular ejection fraction <40% or moderately or severely depressed left ventricular systolic dysfunction

● **G8028:** Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

● **G8029:** Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure

**OR**

● **CPT II 3022F:** Left ventricular ejection fraction  $\geq$ 40% or documentation as normal or mildly depressed left ventricular systolic function

**OR**

**Append a modifier (1P, 2P or 3P) to the following CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria:**

- **4009F** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

Denominator:

Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

**Denominator Coding:**

Patients with heart failure:

Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9

**AND**

E&M visit: 99201-99205, 99212-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

**Instructions:**

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment would be an echocardiogram that provides a numerical value of left ventricular systolic dysfunction or that uses descriptive terms such moderate or severely depressed left ventricular dysfunction. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
  - a. All patients with heart failure will be included unless G8029 is reported.
2. If reporting CPT Category II codes submit the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code, or the CPT Category II code 3022F that indicates patient had LVEF  $\geq 40\%$ . The exclusion modifier codes are: modifier 1P- medical reasons, 2P- patient reasons, and 3P- system reasons.
  - a. All patients with heart failure will be included unless CPT Category II code 4009F with an exclusion modifier is reported.

**Clinical Recommendation Statements:**

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A)(ACC/AHA)

Angiotensin II receptor blockers approved for the treatment of HF (see Table 3) are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant (see text for information regarding patients with angioedema). (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

### ▲ Measure #6: Antiplatelet therapy prescribed for patients with coronary artery disease

#### Description

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease, who were prescribed antiplatelet therapy

#### Instructions:

This is a patient-specific measure that is anticipated to be reported a minimum of once per reporting period. To report this measure use the appropriate CPT Category II code, G-code indicator, the listed ICD-9, and E&M service codes when providing care for patients with coronary artery disease. It is anticipated that physicians providing the primary management of patients with coronary artery disease will report this measure. Antiplatelet therapy consists of aspirin, clopidogrel, or combination of aspirin and dipyridamole.

#### Numerator:

Patients who were prescribed antiplatelet therapy

#### Numerator Coding:

##### **Antiplatelet therapy prescribed**

- **G8036:** Coronary artery disease patient documented to be on antiplatelet therapy

#### OR

**CPT II 4011F:** Antiplatelet therapy prescribed

##### **Antiplatelet therapy prescribed not documented**

- **G8037:** Coronary artery disease patient not documented to be on antiplatelet therapy

##### **Antiplatelet therapy not prescribed by reason of appropriate exclusion;**

- **G8038:** Clinician documented that coronary artery disease patient was not eligible candidate for antiplatelet therapy measure

#### OR

**Append a modifier (1P, 2P or 3P) to the above Category II code (4011F) to report patients with documented circumstances that meet the denominator exclusion criteria.**

1P: documentation of medical reason(s) for not prescribing antiplatelet therapy

2P: documentation of patient reason(s) for not prescribing antiplatelet therapy

3P: documentation of system reason(s) for not prescribing antiplatelet therapy

#### Denominator:

All patients aged 18 years and older with a diagnosis of coronary artery disease

#### Denominator Coding:

ICD-9-CM codes for Coronary artery disease: 414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction); 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)

AND

E&M visit: 99201-99205, 99212-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Clinical Recommendation Statements:

Chronic Stable Angina: Class I – Aspirin 75-325 mg daily should be used routinely in all patients with acute and chronic ischemic heart disease with or without manifest symptoms in the absence of contraindications. Class IIa – Clopidogrel is recommended when aspirin is absolutely contraindicated. Class III – Dipyridamole. Because even the usual oral doses of dipyridamole can enhance exercise-induced myocardial ischemia in patients with stable angina, it should not be used as an antiplatelet agent. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Aspirin 75 to 325 mg/dl in the absence of contraindications. Class I – Clopidogrel 75 qd for patients with a contraindication to ASA. (ACC/AHA)

Acute Myocardial Infarction (AMI): Class I – A dose of aspirin, 160 to 325 mg, should be given on day one of AMI and continued indefinitely on a daily basis thereafter. Trials suggest long-term use of aspirin in the postinfarction patient in a dose as low as 75 mg per day can be effective, with the likelihood that side effects can be reduced. Class IIb – Other antiplatelet agents such as dipyridamole, ticlopidine or clopidogrel may be substituted if true aspirin allergy is present or if the patient is unresponsive to aspirin. (ACC/AHA)

Coronary Artery Bypass Graft Surgery: Aspirin is the drug of choice for prophylaxis against early saphenous graft thrombotic closure and should be considered a standard of care for the first postoperative year. In general, patients are continued on aspirin indefinitely, given its benefit in the secondary prevention of AMI. Ticlopidine is efficacious but offers no advantage over aspirin except as an alternative in the truly aspirin-allergic patient. Clopidogrel offers the potential of fewer side effects compared with ticlopidine as an alternative to aspirin for platelet inhibition. Indobufen appears to be as effective as aspirin for saphenous graft patency over the first postoperative year but with fewer gastrointestinal side effects. Current evidence suggests that dipyridamole adds nothing to the aspirin effect for saphenous graft patency. (ACC/AHA)

**▲ Measure #7: Beta-blocker therapy for coronary artery disease patient with prior myocardial infarction**

Description:

Percentage of patients with coronary artery disease and prior myocardial infarction who were prescribed beta blocker therapy.

Numerator:

Patients who were prescribed beta blocker therapy

**Numerator Coding:**

● **G8033:** Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy **OR**

**CPT II 4006F:** Beta-blocker therapy prescribed

● **G8034:** Prior myocardial infarction - coronary artery disease patient not documented to be on beta -blocker therapy

● **G8035:** Clinician documented that prior myocardial infarction - coronary artery disease patient was not an eligible candidate for beta - blocker therapy measure or the patient had no prior myocardial infarction

**OR**

**Append a modifier (1P, 2P, or 3P) to the following CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria:**

- **4006F** Beta-blocker therapy prescribed

Denominator:

Patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior MI at any time as listed:

**Denominator Coding Option #1:**

Patients with Coronary artery disease:

414.00-414.07, 414.8, 414.9, 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)

**AND**

Patients who prior MI at any time

410.00-410.92, 412

**AND**

E&M visit: 99201-99205, 99212-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

**OR**

**Denominator Coding Option #2**

Patients with prior MI at any time

410.00-410.92 (Acute myocardial infarction), 412 (old MI)

**AND**

E&M visit: 99201-99205, 99212-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with coronary artery disease. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

1. If reporting G-codes, submit the appropriate G-code indicator, the listed ICD-9, and CPT codes.
2. If reporting CPT Category II codes, submit the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes are: modifier 1P- medical reasons, 2P- patient reasons, and 3P- system reasons.

Clinical Recommendation Statements:

Chronic Stable Angina: Class I – Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI. Class I – Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Drugs required in the hospital to control ischemia should be continued after hospital discharge in patients who do not undergo coronary revascularization, patients with unsuccessful revascularization, or patients with recurrent symptoms after revascularization. Upward or downward titration of the doses may be required. Class I – Beta-blockers in the absence of contraindications. (ACC/AHA)

Acute Myocardial Infarction: Class I – All but low-risk patients without a clear contraindication to  $\beta$ -adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely. Class IIa – Low-risk patients without a clear contraindication to  $\beta$ -adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to  $\beta$ -adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

Although no study has determined if long-term  $\beta$ -adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have successfully undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

### **▲ Measure #8: Beta-blocker therapy for left ventricular systolic dysfunction**

#### Description:

Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have left ventricular systolic dysfunction (LVSD) who were prescribed beta blocker therapy

#### Instructions:

This is a patient-specific measure that is anticipated to be reported a minimum of once per reporting period. To report this measure use the appropriate CPT Category II code, G-code, the listed ICD-9, and E&M service codes when providing care to patients with heart failure who have decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. It is anticipated that physicians providing the primary management of patients with heart failure will report this measure. All patients with heart failure will be included unless CPT Category II code 3022F or G-Code G8032 are reported.

#### Numerator:

Patients who were prescribed beta-blocker therapy

#### **Numerator Coding:**

##### **Beta Blocker Therapy Prescribed:**

- **G8030:** Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on beta-blocker therapy

##### **OR**

- **CPT II 4006F:** Beta blocker prescribed

##### **AND**

- **CPT II 3021F:** Left ventricular ejection fraction < 40% or moderately or severely depressed left ventricular systolic function

##### **Beta-blocker prescribed not documented**

- **G8031:** Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on beta-blocker therapy

##### **Beta-blocker not prescribed for reason of appropriate exclusion:**

- **G8032:** Clinician documented that heart failure patient was not eligible candidate for beta-blocker therapy measure

##### **OR**

- **CPT II 3022F:** Left ventricular ejection fraction  $\geq$  40% or documentation as normal or mildly depressed left ventricular systolic function

##### **OR**

**Append a modifier (1P, 2P or 3P) to the above Category II code (4006F) to report patients with documented circumstances that meet the denominator exclusion criteria.**

1P: documentation of medical reason(s) for not prescribing beta-blocker therapy

2P: documentation of patient reason(s) for not prescribing beta-blocker therapy

3P: documentation of system reason(s) for not prescribing beta-blocker therapy



**Denominator:**

*Heart failure patients with left ventricular ejection fraction (LVEF) < 40% or with moderately or severely depressed left ventricular systolic function*

**Denominator Coding:**

Patients with heart failure:

Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

**AND**

E&M visit: 99201-99205, 99212-99215 (E&M); 99341-99350 (home visit); 99304-99310(nursing facility); 99324-99328, 99334-99337 (domiciliary)

**Clinical Recommendation Statements:**

Beta-blockers (using 1 of the 3 proven to reduce mortality, i.e., bisoprolol, carvedilol, and sustained release metoprolol succinate) are recommended for all stable patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (*Class I Recommendation, Level of Evidence: A*) (ACC/AHA)

**Measure #9: Antidepressant medication during acute phase for patient with new episode of major depression**

Numerator:

Patient with an 84 day (12-week) acute treatment of antidepressant medication

Numerator coding

●**G8126:** Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

●**G8127:** Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase

●**G8128:** Patient was not treated with antidepressant medication or was not an eligible candidate for completion of the entire 12 week acute treatment phase

Denominator:

*Patients 18 years and older diagnosed with a New Episode of MDD (major depression) and treated with antidepressant medication:*

E&M Visit: 99201-99205, 99212-99215; psychiatry: 90801, 90802, 90804-90809, 90862,

AND

ICD-9 296.20-296.24, 296.30-296.34, 298.0, 300.4, 309.1, 311 (major depression)

Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. To report this measure use the appropriate quality G-code indicator, the listed ICD-9, and E&M service codes for a patient that is placed on prescription therapy for the treatment of a new episode of major depression disorder. It is anticipated that the clinician that provides the primary management of depression for the patient would submit this measure. Report G8126: 1) For all patients with a diagnosis of Major Depression, New Episode who were prescribed a full 12 week course of antidepressant medication **OR** 2) At the completion of a 12 week course of antidepressant medication. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**\*Measure #10: Stroke and Stroke Rehabilitation: Computed tomography (CT) or Magnetic resonance imaging (MRI) reports**

Description

Percentage of patients aged 18 years and older with the diagnosis of *ischemic stroke* or *TIA* or *intracranial hemorrhage* undergoing CT or MRI of the brain within 24 hours of arrival to the hospital whose final report of the CT or MRI includes documentation of the presence or absence of each of the following: hemorrhage **and** mass lesion **and** acute infarction

Instructions

This is a **visit-specific measure** that is anticipated to be reported for patients with a diagnosis of ischemic stroke, TIA or intracranial hemorrhage and who have had a CT or MRI performed in the hospital setting. Radiologists and other physicians reading the imaging studies of patients with stroke or TIA in the hospital setting are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II
3. Modifiers may not be used – there are no allowable exclusions for this measure

Numerator

Patients whose final report of the initial CT or MRI includes documentation of the presence or absence of each of the following: hemorrhage **and** mass lesion **and** acute infarction

Numerator Coding:

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction Documented (use one of the following coding options)

- **G8242:** Patient documented to have received CT or MRI with presence or absence of hemorrhage, mass lesion and acute infarction documented in the final report.

**OR**

- **CPT II 8242F:** CT or MRI of the brain within 24 hours of arrival to the hospital AND
- **CPT II 8242F:** Presence or absence of hemorrhage and mass lesion and acute infarction documented in final CT or MRI report

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction not Documented

- **G8243:** Patient not documented to have received CT or MRI AND the presence or absence of hemorrhage, mass lesion and acute infarction not documented in the final report.

**OR**

- **CPT II XXXXF:** CT or MRI of the brain performed greater than 24 hours after arrival to the hospital

### **Exclusions**

- None

### Denominator

All patients 18 years and older with the admitting diagnosis of *ischemic stroke* or *TIA* or *intracranial hemorrhage* undergoing CT or MRI of the brain within 24 hours of arrival to the hospital

### Denominator Coding:

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke, transient ischemic attack (TIA), or intracranial hemorrhage AND a Procedure Code to identify patients who had computed tomography (CT) or magnetic resonance imaging (MRI) are required for denominator inclusion:

- **ICD-9-CM Codes:** 430, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9, 432, 432.0, 432.1, 432.9

### AND

- **CPT Codes with or without Modifier 26 to specify professional component:**  
70450, 70460, 70470, 70551, 70552, 70553

### Rationale

The CT and MRI findings are critical to initiating care for the patient with stroke. All CT and MRI reports should address the presence or absence of these three important findings. This documentation is particularly vital in the report of the first imaging study performed after arrival at the hospital, on which initial treatment decisions will be based.

### Clinical Recommendation Statements:

Brain imaging is required to guide acute intervention. (Grade A) There is a uniform agreement that CT accurately identifies most cases of intracranial hemorrhage and helps discriminate nonvascular causes of neurological symptoms, e.g., brain tumor. (Grade B) With the advent of rtPA treatment, interest has grown in using CT to identify subtle, early signs of ischemic brain injury (early infarct signs) or arterial occlusion that might affect decisions about treatment. The presence of these signs is associated with poor outcomes. (Adams, ASA, 2003) (Class A)

A technically adequate head CT scan is required prior to administration of thrombolytic therapy to exclude brain hemorrhage and nonischemic diagnoses. The baseline CT scan is also sensitive for detection of early signs of cerebral infarction. Subtle or limited signs of early infarction on the CT scan are common even within the first 3 h of stroke evolution.

Preliminary data suggest that specific MRI profiles may identify patients who are particularly likely to benefit from thrombolytic therapy. New MRI techniques including perfusion-weighted and diffusion-weighted may detect ischemic injury in the first hour and may reveal the extent of reversible and irreversible injury. In addition, MRI appears to be highly sensitive for identification of acute brain hemorrhage. (Albers, ACCP, 2004)

### **\*Measure #11: Stroke and Stroke Rehabilitation: Carotid imaging report**

#### Description

Percentage of patients aged 18 years and older with the diagnosis of *ischemic stroke* or *TIA* whose final reports of the carotid imaging studies performed, with characterization of an internal carotid stenosis in the 30-99% range, include reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement.

#### Instructions

This is a **visit-specific measure** that is anticipated to be reported for patients with a diagnosis of ischemic stroke or TIA and who have had a carotid imaging study performed. Radiologists and other physicians reading the imaging studies of patients with stroke or TIA in the hospital setting are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

Definition: Reference to “measurements of distal internal carotid diameter” includes angiographic stenosis calculations based on the North American Symptomatic Carotid Endarterectomy Trial (NASCET) methodology **OR**, for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen diameter with NASCET-based stenosis levels

#### Numerator

Patients whose final reports of the carotid imaging studies performed (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) with characterization of an internal carotid stenosis in the 30-99% range, include reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

#### Numerator Coding:

**Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement Documented (use one of the following codes)**

- **G8348:** Internal carotid stenosis patient in the 30-99% range documented to have reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**OR**

**CPT II XXXXF:** Internal carotid stenosis 30 – 99% range

**AND**

**CPT II XXXXF:** Carotid stenosis documented with reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**OR**

- **G8239:** Internal carotid stenosis patient below 30%, reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement not necessary

**OR**

**CPT II XXXXF:** Internal carotid stenosis below 30%

**Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement not Documented**

- **G8240:** Internal carotid stenosis patient in the 30-99% range, and no documentation of reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**Measurements of Distal Internal Carotid Diameter not referenced by Reason of Appropriate Exclusion**

- **G8241:** Clinician documented that patient whose final report of the carotid imaging study performed (neck MRA, neck CTA, neck duplex ultrasound, carotid angiogram), with characterization of an internal carotid stenosis in the 30-99% range, was not an eligible candidate for reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**OR**

**Append a modifier (1P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not including reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**Denominator**

All patients, 18 years and older, with the diagnosis of ischemic stroke or transient ischemic attack (TIA) undergoing carotid imaging

**Denominator Coding:**

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA), and a Procedure Code to identify patients who had carotid imaging are required for denominator inclusion:

- **ICD-9-CM Codes:** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

**AND**

- **CPT Codes with or without Modifier 26 to specify professional component:** 70547, 70548, 70549, 70498, 76536, 75660, 75662, 75665, 75671, 75676, 75680

**Rationale**

Since the clinical decision-making is based on randomized trial evidence and degree of stenosis is an important element of the decision for carotid intervention, characterization of the degree of stenosis needs to be standardized. Requiring that stenosis calculations be based on a denominator of distal internal carotid diameter or, in the case of duplex ultrasound, velocity measurements that have been correlated to angiographic stenosis calculations based on distal internal carotid diameter, makes the measure applicable to both imaging and duplex studies.

Clinical Recommendation Statements:

For patients with symptomatic atherosclerotic carotid stenosis >70%, as defined using the NASCET criteria, the value of carotid endarterectomy (CEA) has been clearly established from the results of 3 major prospective randomized trials: the NASCET, the European Carotid Surgery Trial (ECST), and the Veterans Affairs Cooperative Study Program. Among symptomatic patients with TIAs or minor strokes and high-grade carotid stenosis, each trial showed impressive relative and absolute risk reductions for those randomized to surgery. For patients with carotid stenosis <50%, these trials showed that there was no significant benefit of surgery. (Sacco, ASA, 2006)

It is important to consider that the degree of carotid stenosis in ECST was measured differently than that in NASCET. The degree of carotid stenosis is significantly higher if calculated by the NASCET rather than the ECST method. In summary, it appears that patients with a recent TIA or nondisabling stroke with ipsilateral carotid stenosis benefit from surgery if the stenosis is >50% as measured by the NASCET method; however, this benefit appears to be less pronounced in women. Recently symptomatic patients with >70% stenosis as measured by the NASCET method can expect a far greater benefit from carotid endarterectomy. (Albers, AHA, 1999)

## **\*Measure #12: Primary Open Angle Glaucoma: Optic nerve evaluation**

### Description

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.

### Instructions

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period. It is anticipated that clinicians providing services for the primary management of primary open-angle glaucoma (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for primary open-angle glaucoma.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II codes are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons.

### Numerator

Patients who have an optic nerve head evaluation during one or more office visits within 12 months.

### **Numerator Coding:**

#### **Optic Nerve Head Evaluation Performed (use one of the following codes)**

- **G8298:** Patient documented to have received optic nerve head evaluation

#### **OR**

- **CPT II 2027F:** Optic nerve head evaluation performed

#### **Optic Nerve Head Evaluation not Documented**

- **G8299:** Patient not documented to have received optic nerve head evaluation

#### **Optic Nerve Head Evaluation not Performed by Reason of Appropriate Exclusion**

- **G8300:** Clinician documented that patient was not an eligible candidate for optic nerve head evaluation

#### **OR**

Append a modifier (1P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.



- 1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation

#### **Optic Nerve Head Evaluation not documented due to Insufficient Patient Interaction with Clinician**

- **G8301:** Clinician has not provided care for the POAG patient for the required time for optic nerve head evaluation measure

#### Denominator

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

#### **Denominator Coding:**

Evaluation and Management/Office Visit Codes (CPT) for ophthalmologic services **and** Diagnosis Codes (ICD-9) for primary open-angle glaucoma are required to identify patients for denominator inclusion

- **CPT Codes:** 92002, 92004, 92012, 92014

#### **AND**

- **ICD-9-CM Codes:** 365.01, 365.10, 365.11, 365.12, 365.13, 365.15, 365.52

#### Rationale

Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists (Lee, 2006). Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

#### Clinical Recommendation Statements:

The physical exam focuses on nine elements: visual acuity, pupils, slit-lamp biomicroscopy of the anterior segment, measurement of intraocular pressure (IOP), determination of central corneal thickness, gonioscopy, evaluation of optic nerve head and retinal nerve fiber layer, documentation of optic nerve head appearance, evaluation of fundus (through dilated pupil), and evaluation of the visual field (Level A: II Recommendation for optic nerve head evaluation) (AAO, 2005).

**\*Measure #13: Age-Related Macular Degeneration: Antioxidant supplement prescribed/recommended**

Description

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration with at least one antioxidant vitamin or mineral supplement prescribed/recommended within 12 months

Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that clinicians providing services for the primary management of patients with the diagnosis of age-related macular degeneration (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for age-related macular degeneration.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- (medical reasons).

Numerator:

Patients with at least one antioxidant vitamin or mineral supplement prescribed/recommended within 12 months.

**Definitions:** Antioxidant vitamin and mineral supplements include: vitamins C, E, A (beta-carotene), zinc oxide and cupric oxide

**Numerator Coding:**

**Antioxidant vitamin or mineral supplement prescribed/recommended**

- **G8309:** Patient documented to have been prescribed/recommended antioxidant vitamin or mineral supplement

**OR**

- **CPT II 4007F:** Antioxidant vitamin or mineral supplement prescribed or recommended

**Antioxidant vitamin or mineral supplement prescription/recommendation not documented**

- **G8310:** Patient not documented to have been prescribed/recommended at least one antioxidant vitamin or mineral supplement

**Antioxidant vitamin or mineral supplement not prescribed/recommended by Reason of Appropriate Exclusion**

- **G8311:** Clinician documentation that patient was not an eligible candidate for antioxidant vitamin or mineral supplement.

**OR**

Append a modifier (1P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.

- 1P: Documentation of medical reason(s) for not prescribing or recommending at least one antioxidant vitamin or mineral supplement (e.g. mild AMD, patient does not meet criteria for antioxidant vitamin or mineral supplements as outlined in the AREDS study)

**Antioxidant vitamin or mineral supplement prescribing documentation not available due to Insufficient Patient Interaction with Clinician**

- **G8312:** Clinician has not provided care for the age-related macular degeneration patient for the required time for antioxidant supplement prescription/recommendation measure

**Denominator:**

All patients aged 50 years and older with a diagnosis of age-related macular degeneration

**Denominator Coding:**

Evaluation and Management/Office Visit Codes (CPT) for ophthalmologic services **and** Diagnosis Codes (ICD-9) for age-related macular degeneration are required to identify patients for denominator inclusion

- **CPT Codes:** 92002, 92004, 92012, 92014

**AND**

- **ICD-9-CM Codes:** 362.50, 362.51, 362.52, 362.53, 362.54, 362.56, 362.57

**Rationale**

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye (Age-Related Eye Disease Study Research Group, 2001). From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with *mild* AMD alters the natural history of mild AMD.

**Clinical Recommendation Statements**

According to the American Academy of Ophthalmology, patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports (Level A:1 Recommendation) (AAO, 2005).

#### **\*Measure #14: Age-Related Macular Degeneration: Dilated Macular Examination**

##### Description

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

##### Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that clinicians providing services for the primary management of age-related macular degeneration (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for age-related macular degeneration.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicators, the listed ICD-9 codes, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9 codes, E&M service codes, and appropriate CPT Category II code(s) **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons.

##### Numerator:

Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

##### **Numerator Coding:**

##### **Macular Examination Performed**

- **G8313:** Patient documented to have received macular exam, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

##### **OR**

- **CPT II 2019F:** Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

##### **Macular Examination not Documented**

- **G8314:** Patient not documented to have received macular exam with documentation of presence or absence of macular thickening or hemorrhage and no documentation of level of macular degeneration severity

### **Macular Examination not Performed by Reason of Appropriate Exclusion**

- **G8315:** Clinician documentation that patient was not an eligible candidate for macular examination.

#### **OR**

**Append a modifier (1P or 2P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason(s) for not performing a macular evaluation
- 2P: Documentation of patient reason(s) for not performing a macular evaluation.

### **Macular Examination not Documented due to Insufficient Patient Interaction with Clinician**

- **G8316:** Clinician has not provided care for the age-related macular degeneration patient for the required time for macular examination measurement

#### **Denominator:**

All patients aged 50 years and older with a diagnosis of age-related macular degeneration

#### **Denominator Coding:**

Evaluation and Management/Office Visit Codes (CPT) for ophthalmologic services **and** Diagnosis Codes (ICD-9) for age-related macular degeneration are required to identify patients for denominator inclusion

- **CPT Codes:** 92002, 92004, 92012, 92014

#### **AND**

- **ICD-9-CM Codes:** 362.50, 362.51, 362.52, 362.53, 362.54, 362.56, 362.57

#### **Rationale**

A documented complete macular examination is a necessary prerequisite to determine the presence and severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidant vitamins. Further, periodic assessment is necessary to determine whether there is progression of the disease and to plan the on-going treatment of the disease, since several therapies exist that reduce vision loss once the advanced “wet” form of AMD occurs. While no data exists on the frequency or absence of regular examinations of the macula when patients are under the care of an ophthalmologist for AMD, parallel data for key structural assessments for glaucoma and cataract and diabetic retinopathy suggest that significant gaps are likely.

#### **Clinical Recommendation Statements**

According to the American Academy of Ophthalmology, a stereo biomicroscopic examination of the macula should be completed. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical clues of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, or pigment epithelial elevation (Level A: III Recommendation) (AAO, 2005).

### Measure #15: Cataracts: Assessment of Visual Functional Status

#### Description

Percentage of patients aged 18 years and older with a diagnosis of cataracts who were assessed for visual functional status during one or more office visits within 12 months.

#### Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that clinicians providing services for the primary management of cataracts (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for cataracts.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9 codes, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

#### Numerator:

Patients who were assessed for visual functional status during one or more office visits within 12 months

**Definitions:** Documentation in medical record of visual functional status must include: documentation that patient is operating well with vision or not operating well with vision based on discussion with the patient **OR** documentation of use of a standardized scale or completion of an assessment questionnaire (e.g., VF-14, ADVS (Activities of Daily Vision Scale), VFQ (Visual Function Questionnaire)).

#### **Numerator Coding:**

##### **Visual Functional Status Assessed**

- **G8317:** Patient documented to have visual functional status assessed
- OR**
- **CPT II 1055F:** Visual functional status assessed

##### **Visual Functional Status not Documented**

- **G8318:** Patient documented not to have visual functional status assessed

##### **Visual Functional Status not Assessed by Reason of Appropriate Exclusion**

- **G8319:** Clinician documentation that patient was not eligible candidate for assessment of visual functional status

**OR**

**Append a modifier (1P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason(s) for not assessing for visual function status

**Visual Functional Status not Documented due to Insufficient Patient Interaction with Clinician**

- **G8320:** Clinician has not provided care for the cataract patient for the required time for assessment of visual functional status measurement

**Denominator:**

All patients aged 18 years and older with a diagnosis of cataracts

**Denominator Coding:**

Evaluation and Management/Office Visit Codes (CPT) for ophthalmologic services **and** Diagnosis Codes (ICD-9) for cataract(s) are required to identify patients for denominator inclusion

- **CPT Codes: 92002, 92004, 92012, 92014**

**AND**

- **ICD-9-CM Codes:** 366.00, 366.01, 366.02, 366.03, 366.04, 366.09, 366.10, 366.11, 366.12, 366.13, 366.14, 366.15, 366.16, 366.17, 366.18, 366.19, 366.20, 366.21, 366.22, 366.23, 366.30, 366.31, 366.32, 366.33, 366.34, 366.41, 366.42, 366.43, 366.44, 366.45, 366.46, 366.50, 366.51, 366.52, 366.53, 366.8, 366.9, 743.3X, 743.30, 743.31, 743.32, 743.33, 743.34, 743.39

**Rationale**

The primary reason for cataract surgery is to improve the patient's visual functional status and quality of life, since there is no scientific threshold for measures such as visual acuity when cataract surgery is or is not indicated on a population basis. Data indicate that actual measured performance on important activities varies linearly with visual acuity and contrast sensitivity, two visual parameters directly affected by cataracts (West, 2002). The impact of such decrements varies from person to person. As such, it is vital to assess functioning related to vision prior to cataract surgery. Outcomes of cataract surgery, such as patient satisfaction, have been found to vary directly with the degree of pre-operative impairment (Schein, 1995; Tielsch, 1995).

**Clinical Recommendation Statements**

According to the American Academy of Ophthalmology, the initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health (Level A:III Recommendation) (AAO, 2005).

**\*Measure #16: Cataracts: Documentation of pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation**

Description

Percentage of patients aged 18 years and older who had cataract surgery who had documentation of pre-surgical axial length, corneal power measurement and method of intraocular lens (IOL) power calculation within six months prior to the procedure.

Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who underwent cataract surgery (in either one or both eyes). It is anticipated that clinicians performing cataract surgery will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier, 1P- medical reasons.

Numerator:

Patients who had documentation of pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation within six months prior to the procedure.

Numerator Coding:

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method Documented**

- **G8321:** Patient documented to have had pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation

**OR**

- **CPT II 3073F:** Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation documented within six months prior to surgery.

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Documented**

- **G8322:** Patient not documented to have had pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation.

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Documented by Reason of Appropriate Exclusion**



- **G8323:** Clinician documentation that patient was not an eligible candidate for pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation.

**OR**

**Append a modifier (1P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason(s) for not recording pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation.

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Documented due to Insufficient Patient Interaction with Clinician**

- **G8324:** Clinician has not provided care for the cataract patient for the required time for pre-surgical measurement and intraocular lens power calculation measure

**Denominator:**

All patients aged 18 years and older who had cataract surgery

**Denominator Coding:**

CPT Codes or ICD-9-CM Procedure Codes indicating cataract surgery are required for denominator inclusion

- **CPT Codes:** 66820, 66821, 66830, 66850, 66852, 66982, 66983, 66984, 66985

OR

- **ICD-9-CM Procedure Codes** 13.11, 13.19, 13.2, 13.3, 13.41, 13.42, 13.43, 13.51, 13.59, 13.64, 13.65, 13.66, 13.69, 13.70, 13.71, 13.72

**Rationale**

An important outcome of cataract surgery is improved visual function and attainment of the patient's desired refractive outcome. Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. These data are not always documented in the patient record (McGlynn, 2003). Further, there are various methods to measure axial length and corneal power, and different lens calculation formula that can be used. The rationale for documenting these measurements and IOL power calculation formula used is to help increase the likelihood of achieving an appropriate postoperative refractive target, and to be able to review potential causes of any postoperative refractive surprises (postoperative refraction does not equal the plan/targeted refraction).

**Clinical Recommendation Statements**

Achieving the targeted postoperative refraction requires measuring axial length accurately, determining corneal power, and using the most appropriate IOL power formula. (AAO ).

#### **\*Measure #17: Cataracts: Pre-Surgical dilated fundus evaluation**

##### Description

Percentage of patients aged 18 years and older who had cataract surgery who had a fundus evaluation performed within six months prior to the procedure.

##### Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who underwent cataract surgery (in either one or both eyes). It is anticipated that clinicians performing cataract surgery will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9 codes, E&M service codes and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed with this measure is: modifier 2P- patient reasons.

##### Numerator:

Patients who had a dilated fundus evaluation performed within six months prior to the procedure.

##### Numerator Coding:

##### **Pre-surgical Fundus Evaluation Performed**

- **G8325:** Patient documented to have received fundus evaluation
- OR**
- **CPT II 2020F:** Dilated fundus evaluation performed within six months prior to cataract surgery

##### **Pre-surgical Fundus Evaluation not Documented**

- **G8326:** Patient not documented to have received fundus evaluation

##### **Pre-surgical Fundus Evaluation not Performed by Reason of Patient Exclusion**

- **G8327:** Patient was not an eligible candidate for pre-surgical fundus evaluation
- OR**
- Append a modifier (2P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**
- **2P:** Documentation of patient reason(s) for not performing a dilated fundus evaluation

##### **Pre-surgical Fundus Evaluation not Documented due to Insufficient Patient Interaction with Clinician**

- **G8328:** Clinician has not provided care for the cataract patient for the required time for fundus evaluation measurement.

Denominator:

All patients aged 18 years and older who had cataract surgery

**Denominator Coding:**

CPT Codes or ICD-9-CM Procedure Codes indicating cataract surgery are required for denominator inclusion

- **CPT Codes:** 66820, 66821, 66830, 66850, 66852, 66982, 66983, 66984, 66985

**OR**

- **ICD-9-CM Procedure Codes** 13.11, 13.19, 13.2, 13.3, 13.41, 13.42, 13.43, 13.51, 13.59, 13.64, 13.65, 13.66, 13.69, 13.70, 13.71, 13.72

Rationale

All patients undergoing cataract surgery should have a comprehensive eye examination prior to the scheduled procedure, with particular attention to the presence of other ocular conditions that may impact the advisability and expected outcomes of surgery. The presence of a dilated fundus examination is often lacking in pre-operative assessments (Lee, 1996). In addition, the outcomes of cataract surgery are significantly impacted by the presence or absence of comorbid ocular conditions (Schein, 1995; Tielsch, 1995; Mangione, 1995).

Clinical Recommendation Statements

The initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health (Level A:III Recommendation) (AAO, 2001).

**\*Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**

Description

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months.

Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that ophthalmologists providing services for people with diabetic retinopathy (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for diabetic retinopathy.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the appropriate ICD-9, E&M service codes, and CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons.

Numerator:

Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

**Definitions:** Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND Documentation of whether macular edema was present or absent

**Numerator Coding:**

**Macular or Fundus Exam Performed**

- **G8329:** Patient documented to have received dilated macular or fundus exam with level of severity of retinopathy AND the presence or absence of macular edema documented

**OR**

- **CPT II 2021F:** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

### **Macular or Fundus Exam not Documented**

- **G8330:** Patient not documented to have received dilated macular or fundus exam with level of severity of retinopathy AND the presence or absence of macular edema not documented

### **Macular or Fundus Exam not Performed by Reason of Patient Exclusion**

- **G8331:** Clinician documentation that patient was not an eligible candidate for dilated macular or fundus exam.

#### **OR**

Append a modifier (1P or 2P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.

- 1P: Documentation of medical reason(s) for not performing a dilated macular or fundus examination
- 2P: Documentation of patient reason(s) for not performing a dilated macular or fundus examination.

### **Macular or Fundus Exam not Documented due to Insufficient Patient Interaction with Clinician**

- **G8332:** Clinician has not provided care for the diabetic retinopathy patient for the required time for macular edema and retinopathy measurement

#### Denominator:

All patients aged 18 years and older with a diagnosis of diabetic retinopathy

#### Denominator Coding:

Evaluation and Management/Office Visit Codes (CPT) for ophthalmologic services **and** Diagnosis Codes (ICD-9) for diabetic retinopathy are required to identify patients for denominator inclusion

- **CPT codes:** 92002, 92004, 92012, 92014

#### AND

- **ICD-9 CM Codes:** 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07

#### Rationale

Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study - DRS, Early Treatment Diabetic Retinopathy Study - ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

#### Clinical Recommendation Statements

Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage (Level A:III Recommendation) (AAO, 2003).

**\*Measure #19: Diabetic Retinopathy: Communication with the physician managing ongoing diabetes care**

Description

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the macular or fundus exam at least once within 12 months.

Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that ophthalmologists providing services for people with diabetic retinopathy (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for diabetic retinopathy.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed with this measure are: modifier 1P – medical reasons, 2P- patient reasons.

Numerator:

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

**Definitions:** Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the physician managing the patient's diabetic care Or a copy of a letter in the medical record to the physician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

**Numerator Coding:**

**Macular or Fundus Exam Findings Communicated**

- **G8333:** Patient documented to have had findings of macular or fundus exam communicated to the physician managing the diabetes care

**OR**

- **CPT II 5010F:** Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care

**AND**

- **CPT II 2021F:** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.

#### **Dilated Macular or Fundus Exam Findings not Documented**

- **G8335:** Documentation of findings of macular or fundus exam not communicated to the physician managing the patient's ongoing diabetes care

#### **Dilated Macular or Fundus Exam Findings not Communicated by Reason of Patient Exclusion**

- **G8336:** Clinician documentation that patient was not an eligible candidate for the findings of their macular or fundus exam being communicated to the physician managing their diabetes care.

#### **OR**

**Append a modifier (1P or 2P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
- 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

#### **Macular or Fundus Exam Findings not Documented due to Insufficient Patient Interaction with Clinician**

- **G8336:** Clinician has not provided care for the diabetic retinopathy patient for the required time for physician communication measurement

#### **Denominator:**

All patients aged 18 years and older with a diagnosis of diabetic retinopathy

#### **Denominator Coding:**

Evaluation and Management/Office Visit Codes (CPT) for ophthalmologic services **and** Diagnosis Codes (ICD-9) for diabetic retinopathy are required to identify patients for denominator inclusion

- **CPT Codes:** 92002, 92004, 92012, 92014

#### **AND**

- **ICD-9-CM Codes:** 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07

#### **Rationale**

The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease (Diabetes Control and Complications Trial - DCCT, UK Prospective Diabetes Study - UKPDS).



#### Clinical Recommendation Statements

While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician (Level A: III Recommendation). (AAO, 2003).

**\*Measure #20: Perioperative Care: Timing of antibiotic prophylaxis – ordering physician**

Description

Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics who have an order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who undergo surgical procedures with the indications for prophylactic antibiotics during the reporting period. It is anticipated that surgeons providing the surgical procedures will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients that are included in the denominator; in some instances, CPT II or G-Codes may also be needed to define the denominator. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P-medical reasons.

Numerator

Surgical patients who have an order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

Numerator instruction:

There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that antibiotic is to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) **OR** documentation that antibiotic *has* been given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

**Numerator Coding:**

**Table 1A: The antimicrobial drugs listed below are considered prophylactic antibiotics for the purposes of this measure.**

<ul style="list-style-type: none"><li>• Ampicillin/sulbactam</li><li>• Aztreonam</li><li>• Cefazolin</li><li>• Cefmetazole</li></ul>	<ul style="list-style-type: none"><li>• Cefoxitin</li><li>• Cefuroxime</li><li>• Ciprofloxacin</li><li>• Clindamycin</li></ul>	<ul style="list-style-type: none"><li>• Gentamicin</li><li>• Levofloxacin</li><li>• Metronidazole</li><li>• Moxifloxacin</li></ul>
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<ul style="list-style-type: none"> <li>• Cefotetan</li> </ul>	<ul style="list-style-type: none"> <li>• Erythromycin base</li> <li>• Gatifloxacin</li> </ul>	<ul style="list-style-type: none"> <li>• Neomycin</li> <li>• Vancomycin</li> </ul>
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**Documentation of order for prophylactic antibiotic (written order, verbal order, or standing order/protocol) (use one of the following codes)**

- **G8191:** Clinician documented to have given order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**OR**

- **CPT II XXXXF:** Documentation of order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**Documentation that antibiotic has been given within one hour prior to the surgical incision (or start of procedure when no incision is required)**

- **G8192:** Clinician documented to have given the prophylactic antibiotic within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

**OR**

- **CPT II XXXXF:** Documentation that prophylactic antibiotic was given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**Order for Prophylactic Antibiotic not documented**

- **G8193:** Clinician did not document that an order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required) was given

**Order for Prophylactic Antibiotic Not Given by Reason of Appropriate Exclusions:**

- **G8194:** Clinician documented that patient was not an eligible candidate for prophylactic antibiotic

**OR**

- **Append a modifier (1P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**
  - 1P: documentation of medical reason(s) for not ordering an antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

**Denominator**

All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics

**Denominator Coding:**

Surgical procedure codes for which prophylactic antibiotics are indicated for denominator inclusion

<b>Surgical Procedure</b>	<b>CPT CODE</b>
<b>Integumentary</b>	15734, 15738, 15946, 15936, 15937, 15956, 19120, 19125, 19140, 19160, 19162, 19180, 19182, 19200, 19220, 19240, 19260, 19271, 19272, 19361, 19364, 19366, 19367, 19368, 19369
<b>Le Fort Fractures</b>	21422, 21423, 21346, 21347, 21348, 21432, 21433, 21435, 21436
<b>Mandibular Fracture</b>	21454, 21461, 21462, 21465, 21470
<b>Spine</b>	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
<b>Hip Reconstruction</b>	27125, 27130, 27132, 27134, 27137, 27138
<b>Trauma (Fractures)</b>	27235, 27236, 27244, 27245, 27758, 27759, 27766, 27792, 27814
<b>Knee Reconstruction</b>	27440, 27441, 27442, 27443, 27445, 27446, 27447
<b>Trauma</b>	27758, 27759, 27766, 27792, 27814
<b>Laryngectomy</b>	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
<b>Vascular</b>	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35641, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
<b>Spleen and Lymph Nodes</b>	38100, 38101, 38115, 38120, 38700, 38720, 38724, 38740, 38745, 38760, 38765
<b>Glossectomy</b>	41130, 41135, 41140, 41145, 41150, 41153, 41155
<b>Esophagus</b>	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
<b>Stomach</b>	43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43653, 43750, 43752, 43760, 43761, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
<b>Small Intestine</b>	44005, 44010, 44020, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
<b>Colon and Rectum</b>	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44152,

	44153, 44155, 44156, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44950, 44960, 44970
<b>Anus and Rectum</b>	45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
<b>Hepatic Surgery</b>	47010, 47011, 47015, 47100, 47120, 47122, 47125, 47130, 47133, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400
<b>Biliary Surgery</b>	47420, 47425, 47460, 47480, 47490, 47510, 47511, 47525, 47530, 47560, 47561, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47716, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
<b>Pancreas</b>	48001, 48005, 48020, 48100, 48102, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48180, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48550, 48554, 48556
<b>Abdomen, Peritoneum, &amp; Omentum</b>	49000, 49002, 49010, 49180, 49200, 49201, 49215
<b>Renal Transplant</b>	50300, 50320, 50340, 50360, 50365, 50370, 50380
<b>Gynecologic Surgery</b>	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58552, 58553, 58554, 58951, 58953, 58954, 58956
<b>Acoustic Neuroma</b>	61591, 61595, 61596, 61598, 61520, 61526, 61530, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
<b>Cochlear Implants</b>	69930
<b>Neurological Surgery</b>	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64721,
<b>Cardiothoracic Surgery</b>	33120, 33130, 33140-33141, 33200-33201, 33245-33246, 33250-33251, 33253, 33261, 33300, 33305, 33310, 33315, 33320-33322, 33332, 33335, 33400-33401, 33403-33406, 33410, 33411, 33413, 33416, 33422, 33425-33427, 33430, 33460, 33463-33465, 33475, 33496, 33510-33519, 33521-33523, 33530, 33533-33536, 33542, 33545, 33548, 33572, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35820
<b>General Thoracic Surgery</b>	19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32035-32036, 32095, 32100, 32110, 32120, 32124,

	32140-32141, 32150, 32200, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500-32501, 32540, 32601-32606, 32650-32665, 32800, 32810, 32815, 32900, 32905-32906, 32940, 33020, 33025, 33030-33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35481, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 43108, 43112-43113, 43116-43118, 43121, 43123- 43135, 43310, 43341, 43351, 60521-60522, 64746
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### **Rationale**

The appropriate timing of administration of prophylactic antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Specifying the time of administration in the order is critical as available evidence suggests that the drug should be received within one hour before incision for maximum antimicrobial effect.

### **Clinical Recommendation Statements:**

The anti-infective drug should ideally be given within 30 minutes to 1 hour before the initial incision to ensure its presence in an adequate concentration in the targeted tissues. For most procedures, scheduling administration at the time of induction of anesthesia ensures adequate concentrations during the period of potential contamination. Exceptions: cesarean procedures (after cross clamping of the umbilical cord); colonic procedures (starting 19 hours before the scheduled time of surgery). (ASHP)

Infusion of the first antimicrobial dose should begin within 60 min before incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 min before incision to prevent antibiotic-associated reactions. Although research has demonstrated that administration of the antimicrobial at the time of anesthesia induction is safe and results in adequate serum and tissue drug levels at the time of incision, there was no consensus that the infusion must be completed before incision. (SIPGWW)

**\*Measure #21: Perioperative Care: Selection of prophylactic antibiotic – first OR second generation cephalosporin**

Description

Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.

Instruction

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who undergo surgical procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic during the reporting period. It is anticipated that surgeons providing the surgical procedures will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients that are included in the denominator; in some instances, CPT II or G-Codes may also be needed to define the denominator. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons.

Numerator:

Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

Numerator instruction:

There must be documentation of order (written order, verbal order, or standing order/protocol) for cefazolin OR cefuroxime for antimicrobial prophylaxis OR documentation that cefazolin OR cefuroxime was given.

**Numerator Coding:**

**Acceptable First and Second Generation Cephalosporin Prophylactic Antibiotics**

First generation cephalosporin: cefazolin

Second generation cephalosporin: cefuroxime

**Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol) (use one of the following codes)**

- **G8198:** Patient documented to have order for cefazolin OR cefuroxime for antimicrobial prophylaxis

**OR**

- **CPT II XXXXF:** Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis

**Documentation that cefazolin OR cefuroxime has been given for antimicrobial prophylaxis**

- **G8199:** Clinician documented to have given cefazolin OR cefuroxime for antimicrobial prophylaxis

Note: A single CPT Category II code is provided for antibiotic ordered or antibiotic given.

**Order for First OR Second Generation Cephalosporin not documented**

- **G8200:** Order for cefazolin OR cefuroxime for antimicrobial prophylaxis not documented

**Order for First or Second Generation Cephalosporin Not Given by Reason of Appropriate Exclusions:**

- **G8201:** Patient was not an eligible candidate for cefazolin OR cefuroxime for antimicrobial prophylaxis

**OR**

- **Append a modifier (1P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**
  - 1P: documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis

**Denominator:**

All surgical patients aged 18 years and older undergoing procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic

**Denominator Coding:**

Surgical procedure codes for which prophylactic antibiotics are indicated for denominator inclusion

<b>Surgical Procedure</b>	<b>CPT CODE</b>
<b>Integumentary</b>	15734, 15738, 15946, 15936, 15937, 15956, 19120, 19125, 19140, 19160, 19162, 19180, 19182, 19200, 19220, 19240, 19260, 19271, 19272, 19361, 19364, 19366, 19367, 19368, 19369
<b>Spine</b>	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
<b>Neurological Surgery</b>	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64721,
<b>Hip Reconstruction</b>	27125, 27130, 27132, 27134, 27137, 27138
<b>Trauma (Fractures)</b>	27235, 27236, 27244, 27245, 27758, 27759, 27766, 27792, 27814
<b>Knee Reconstruction</b>	27440, 27441, 27442, 27443, 27445, 27446, 27447



<b>Vascular</b>	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35641, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
<b>Spleen and Lymph Nodes</b>	38100, 38101, 38115, 38120, 38700, 38720, 38724, 38740, 38745, 38760, 38765
<b>Esophagus</b>	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
<b>Stomach</b>	43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43653, 43750, 43752, 43760, 43761, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
<b>Small Intestine</b>	44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
<b>Hepatic Surgery</b>	47010, 47011, 47015, 47100, 47120, 47122, 47125, 47130, 47133, 47134, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400
<b>Biliary Surgery</b>	47420, 47425, 47460, 47480, 47490, 47510, 47511, 47525, 47530, 47560, 47561, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47716, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
<b>Pancreas</b>	48001, 48005, 48020, 48100, 48102, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48180, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48550, 48554, 48556
<b>Abdomen, Peritoneum &amp; Omentum</b>	49000, 49002, 49010, 49180, 49200, 49201, 49215
<b>Renal Transplant</b>	50300, 50320, 50340, 50360, 50365, 50370, 50380
<b>Gynecologic Surgery</b>	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58552, 58553, 58554, 58951, 58953, 58954, 58956
<b>Cardiothoracic Surgery</b>	33120, 33130, 33140-33141, 33200-33201, 33245-33246, 33250-33251, 33253, 33261, 33300, 33305, 33310, 33315, 33320-33322, 33332, 33335, 33400-33401, 33403-33406, 33410, 33411, 33413, 33416, 33422, 33425-33427, 33430, 33460, 33463-33465, 33475, 33496, 33510-33519, 33521-33523, 33530, 33533-33536, 33542, 33545, 33548, 33572, 35021, 35211,

	35216, 35241, 35246, 35271, 35276, 35311, 35820
<b>General Thoracic Surgery</b>	19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32035-32036, 32095, 32100, 32110, 32120, 32124, 32140-32141, 32150, 32200, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500-32501, 32540, 32601-32606, 32650-32665, 32800, 32810, 32815, 32900, 32905-32906, 32940, 33020, 33025, 33030-33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35481, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 43108, 43112-43113, 43116-43118, 43121, 43123-43135, 43310, 43341, 43351, 60521-60522, 64746

#### Rationale

Current published evidence supports the use of either cefazolin, a first generation cephalosporin, or cefuroxime, a second generation cephalosporin, for many surgical procedures, in the absence of  $\beta$ -lactam allergy. An alternative antimicrobial regimen may be appropriate depending on the antimicrobial susceptibility pattern in an individual institution (potentially a medical reason for excluding patients treated at that institution from this measure.)

#### Clinical Recommendation Statements:

For most procedures, cefazolin should be the agent of choice because of its relatively long duration of action, its effectiveness against the organisms most commonly encountered in surgery, and its relatively low cost. (ASHP)

In operations for which cephalosporins represent appropriate prophylaxis, alternative antimicrobials should be provided to those with a high likelihood of serious adverse reaction or allergy on the basis of patient history or diagnostic tests such as skin testing.

The preferred antimicrobials for prophylaxis in patients undergoing hip or knee arthroplasty are cefazolin and cefuroxime. Vancomycin or clindamycin may be used in patients with serious allergy or adverse reactions to  $\beta$ -lactams.

The recommended antimicrobials for cardiothoracic and vascular operations include cefazolin or cefuroxime. For patients with serious allergy or adverse reaction to  $\beta$ -lactams, vancomycin is appropriate, and clindamycin may be an acceptable alternative. (SIPGWW)

**\*Measure #22: Perioperative Care: Discontinuation of prophylactic antibiotics (non-cardiac procedures)**

Description

Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time

Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who undergo surgical procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic. It is anticipated that surgeons providing the surgical procedures will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients that are included in the denominator; in some instances, CPT II or G-Codes may also be needed to define the denominator. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code OR the CPT Category II code WITH the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

Numerator:

Non-cardiac surgical patients aged 18 years and older who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time

Numerator Instruction:

There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 24 hours of surgical end time **OR** documentation that prophylactic antibiotic was discontinued within 24 hours of surgical end time.

**Numerator Coding:**

**Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 24 hours of surgical end time**

- **G8202:** Clinician documented an order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time

**AND**

- **G8206:** Clinician documented that prophylactic antibiotic was given

**OR**

- **CPT II XXXF:** Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure

**AND**

- **CPT II XXXXF:** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

**Documentation that prophylactic antibiotics were discontinued**

- **G8203:** Clinician documented that prophylactic antibiotics were discontinued within 24 hours of surgical end time

Note: A single CPT Category II code is provided for documentation that antibiotic discontinuation ordered or that antibiotic discontinuation accomplished. Report CPT Category II code above (ordered to be discontinued) if antibiotics were discontinued within 24 hours.

**Order for Discontinuation of prophylactic antibiotics not documented**

- **G8204:** Clinician did not document an order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time

**Prophylactic Antibiotics not Discontinued by Reason of Patient Exclusion**

- **G8205:** Clinician documented that patient was not an eligible candidate for prophylactic antibiotic discontinuation within 24 hours of surgical end time

**OR**

- **CPT II XXXXF:** Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

**OR**

- **Append a modifier (1P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**
  - 1P: documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time

**Denominator:**

All non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic.

**Denominator instruction:**

For the purpose of this measure of antibiotic discontinuation, patients may be counted as having “received a prophylactic antibiotic” if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.

**Denominator Coding:**

Non-Cardiac surgical procedure codes for which prophylactic antibiotic is indicated for denominator inclusion

<b>Surgical Procedure</b>	<b>CPT CODE</b>
<b>Integumentary</b>	15734, 15738, 15946, 15936, 15937, 15956, 19120, 19125, 19140, 19160,

	19162, 19180, 19182, 19200, 19220, 19240, 19260, 19271, 19272, 19361, 19364, 19366, 19367, 19368, 19369
<b>Le Fort Fractures</b>	21422, 21423, 21346, 21347, 21348, 21432, 21433, 21435, 21436
<b>Mandibular Fracture</b>	21454, 21461, 21462, 21465, 21470
<b>Spine</b>	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
<b>Neurological Surgery</b>	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64721,
<b>Hip Reconstruction</b>	27125, 27130, 27132, 27134, 27137, 27138
<b>Trauma (Fractures)</b>	27235, 27236, 27244, 27245
<b>Knee Reconstruction</b>	27440, 27441, 27442, 27443, 27445, 27446, 27447
<b>Trauma</b>	27758, 27759, 27766, 27792, 27814
<b>Laryngectomy</b>	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
<b>Vascular</b>	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35641, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
<b>Spleen and Lymph Nodes</b>	38100, 38101, 38115, 38120, 38700, 38720, 38724, 38740, 38745, 38760, 38765
<b>Glossectomy</b>	41130, 41135, 41140, 41145, 41150, 41153, 41155
<b>Esophagus</b>	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
<b>Stomach</b>	43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43653, 43750, 43752, 43760, 43761, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
<b>Small Intestine</b>	44005, 44010, 44020, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
<b>Colon and Rectum</b>	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44152, 44153, 44155, 44156, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322,

	44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44950, 44960, 44970
<b>Anus and Rectum</b>	45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
<b>Hepatic Surgery</b>	47010, 47011, 47015, 47100, 47120, 47122, 47125, 47130, 47133, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400
<b>Biliary Surgery</b>	47420, 47425, 47460, 47480, 47490, 47510, 47511, 47525, 47530, 47560, 47561, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47716, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
<b>Pancreas</b>	48001, 48005, 48020, 48100, 48102, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48180, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48550, 48554, 48556
<b>Abdomen, Peritoneum, &amp; Omentum</b>	49000, 49002, 49010, 49180, 49200, 49201, 49215
<b>Renal Transplant</b>	50300, 50320, 50340, 50360, 50365, 50370, 50380
<b>Gynecologic Surgery</b>	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58552, 58553, 58554, 58951, 58953, 58954, 58956
<b>Acoustic Neuroma</b>	61591, 61595, 61596, 61598, 61520, 61526, 61530, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
<b>Cochlear Implants</b>	69930
<b>General Thoracic Surgery</b>	19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32035-32036, 32095, 32100, 32110, 32120, 32124, 32140-32141, 32150, 32200, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500-32501, 32540, 32601-32606, 32650-32665, 32800, 32810, 32815, 32900, 32905-32906, 32940, 33020, 33025, 33030-33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35481, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 43108, 43112-43113, 43116-43118, 43121, 43123-43135, 43310, 43341, 43351, 60521-60522, 64746

#### Rationale

There is no evidence there is added benefit of prolonged prophylactic antibiotic use. Prolonged use may increase antibiotic resistant organisms.

Clinical Recommendation Statements:

At a minimum, antimicrobial coverage must be provided from the time of incision to closure of the incision. For most procedures, the duration of antimicrobial prophylaxis should be 24 hours or less, with the exception of cardiothoracic procedures (up to 72 hours' duration) and ophthalmic procedures (duration not clearly established). (ASHP)

Prophylactic antimicrobials should be discontinued within 24 hours after the operation. (SIPGWW)

**\*Measure #23: Perioperative Care: Venous thromboembolism (VTE) prophylaxis (when indicated in ALL patients)**

Description

Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.

Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who undergo procedures for major, open urologic procedures, elective hip or knee arthroplasty, hip fracture surgery, or major neurosurgery, who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis within 24 hours prior to incision time or within 24 hours after surgery end time. It is anticipated that surgeons providing the surgical procedures will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients that are included in the denominator; in some instances, CPT II or G-Codes may also be needed to define the denominator. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicators, the listed ICD-9 codes, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9 codes, E&M service codes, and appropriate CPT Category II code(s) **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

Numerator:

Surgical patients who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

Numerator instruction:

There must be documentation of order (written order, verbal order, or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was given.

**Numerator Coding:**

**Appropriate VTE Prophylaxis Ordered**

- **G8212:** Clinician documented an order was given for appropriate VTE prophylaxis to be given within 24 hrs prior to incision time or 24 hours after surgery end time

**OR**

- **CPT II XXXXF:** Documentation that an order was given for VTE prophylaxis to be given within 24 hrs prior to incision time or within 24 hours after surgery end time



**Documentation that VTE Prophylaxis was given**

- **G8213:** Clinician documented to have given VTE prophylaxis within 24 hrs prior to incision time or 24 hours after surgery end time

Note: A single CPT Category II code is provided for VTE prophylaxis ordered or VTE prophylaxis given

**Order for VTE Prophylaxis not documented**

- **G8214:** Clinician did not document an order was given for appropriate VTE prophylaxis to be given within 24 hrs prior to incision time or 24 hours after surgery end time

**VTE Prophylaxis Not Ordered by Reason of Patient Exclusion**

- **G8215:** Clinician documented that patient was not an eligible candidate for VTE prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time

**OR**

**Append a modifier (1P) to the CPT Category II code above to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for patient not receiving LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis within 24 hours prior to incision time or 24 hours after surgery end time

**Denominator:**

All surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients

**Denominator Coding:**

Surgical procedure codes for which VTE prophylaxis is indicated for denominator inclusion

<b>Surgical Procedure</b>	<b>CPT CODE</b>
<b>Neurological Surgery</b>	22558, 22600, 22612, 22630, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276
<b>Hip Reconstruction</b>	27125, 27130, 27132, 27134, 27137, 27138
<b>Knee Reconstruction</b>	27440, 27441, 27442, 27443, 27445, 27446, 27447
<b>Urologic Surgery</b>	50020, 50220, 50225, 50230, 50234, 50236, 50240, 50715, 50722, 50725, 50800, 50810, 50815, 50820, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51900, 51960, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845
<b>Gynecologic Surgery</b>	58951, 58953, 58954, 58956, 56630-56634, 56637, 56640, 58200, 58210, 58240, 58285
<b>Hip Fracture Surgery</b>	27235, 27235, 27244, 27245

<b>General Surgery</b>	19120, 19125, 19140, 19160, 19162, 19180, 19182, 19200, 19220, 19240, 19260, 19271, 19272, 19316, 19318, 19324, 19325, 19328, 19330, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38760, 38765, 38770, 38780, 39501, 39502, 39503, 39520, 39530, 39531, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44152, 44153, 44155, 44156, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 46715, 46716, 46730, 46735, 46740, 46742, 46744, 46746, 46748, 46750, 46751, 46753, 46754, 46760, 46761, 46762, 47010, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400, 47420, 47425, 47460, 47480, 47500, 47505, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47716, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48005, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48180, 48500, 48510, 48520, 48540, 48545, 48547, 48554, 48556, 49000, 49002, 49010, 49020, 49040, 49060, 49200, 49201, 49215, 49220, 49250, 49255, 49320, 49321, 49322, 49323, 49560, 49561, 49565, 49566, 49570, 50320, 50340, 50360, 50365, 50370, 50380, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650
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Rationale

This measure addresses VTE risk based on surgical procedure. VTE prophylaxis is appropriate for all patients undergoing these procedures regardless of individual *patient* thromboembolic risk factors.

Additional work is needed to determine if a physician-level measure for VTE prophylaxis can be developed to address individual patient thromboembolic risk factors, in addition to procedural risk, without creating data collection burden. Many of these procedures are done in hospitals and ASCs, but quite a few are performed in the physician's office. There are many reasons for the differences in the site of service, including that breast lesions and breast tissue varies considerably. Some women have a small breast and a small lesion that can be expeditiously treated as a minor office procedure done in 20 minutes under local anesthesia. In this instance, the evidence for DVT prophylaxis is simply not present. Other patients have small or large lesions located in difficult positions within a dense complex breast. In this instance, the patients have long procedures under general anesthesia. Both of these instances can occur within the same CPT code. It should be noted that the number of medical exclusions for these codes will likely be much higher than other codes to account for the variation in major and minor procedures within the same CPT code. Duration of VTE prophylaxis is not specified in the measure due to varying guideline recommendations for different patient populations.

#### Clinical Recommendation Statements

Recommend that mechanical methods of prophylaxis be used primarily in patients who are at high risk of bleeding (Grade 1C+) or as an adjunct to anticoagulant-based prophylaxis. (Grade 2A)

Recommend **against** the use of aspirin alone as prophylaxis against VTE for any patient group. (Grade 1A)

Recommend consideration of renal impairment when deciding on doses of LMWH, fondaparinux, the direct thrombin inhibitors, and other antithrombotic drugs that are cleared by the kidneys, particularly in elderly patients and those who are at high risk for bleeding. (Grade 1C+).

Moderate-risk general surgery patients are those patients undergoing a nonmajor procedure and are between the ages of 40 and 60 years or have additional risk factors, or **those patients who are undergoing major operations and are <40 years of age with no additional risk factors**. Recommend prophylaxis with LDUH, 5,000 U bid or LMWH  $\leq 3,400$  U once daily (both Grade 1A).

Higher-risk general surgery patients are those undergoing nonmajor surgery and are >60 years of age or have additional risk factors, or **patients undergoing major surgery who are >40 years of age or have additional risk factors**. Recommend thromboprophylaxis with LDUH, 5,000 U tid or LMWH, >3,400 U daily (both Grade 1A).

Recommend that thromboprophylaxis be used in all major gynecologic surgery patients (Grade 1A).

For patients undergoing major, open urologic procedures, recommend routine prophylaxis with LDUH twice daily or three times daily (Grade 1A).

Patients undergoing major orthopedic surgery, which includes hip and knee arthroplasty and hip fracture repair, represent a group that is at particularly high risk for VTE, and routine thromboprophylaxis has been the standard of care for >15 years. Elective total hip replacement: routine use of LMWH, fondaparinux, or adjusted-dose VKA (all Grade 1A). Elective total knee arthroplasty: routine thromboprophylaxis using LMWH, fondaparinux, or adjusted-dose VKA (all Grade 1A). Hip fracture surgery: routine use of fondaparinux (Grade 1A), LMWH (Grade 1C+), adjusted-dose VKA (Grade 2B), or LDUH (Grade 1B).

For major orthopedic surgical procedures, recommend that a decision about the timing of the initiation of pharmacologic prophylaxis be based on the efficacy-to-bleeding tradeoffs for that particular agent (Grade 1A). For LMWH, there are only small differences between starting preoperatively or postoperatively, both options acceptable (Grade 1A).

Recommend that thromboprophylaxis be routinely used in patients undergoing major neurosurgery (Grade 1A). (ACCP)

**\*Measure #24: Osteoporosis: Communication with the physician managing ongoing care post fracture**

Description

Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

Instructions

This is a **patient specific measure** that is anticipated to be reported after the occurrence of a fracture during the reporting period. It is anticipated that patients with a fracture of the hip, spine or distal radius would have documentation in the medical record of communication from the physician treating the fracture to the physician managing the patient's ongoing care that the fracture occurred and that the patient was or should be tested or treated for osteoporosis. The communication to the physician managing the on-going care of the patient should occur within three months of treatment for the fracture. Clinicians who treated the hip, spine or distal radial fracture are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD 9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons.

Numerator

Patients with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**Definitions:** Communication may include: Documentation in the medical record indicating that the physician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the physician managing the patient's on-going care **OR** a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

**Numerator Coding:**

**Post-Fracture Care Communication Documented (use one of the following codes)**

- **G8337:** Clinician documented that communication was sent to the physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**OR**

- **CPT II 5015F:** Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

#### **Post-Fracture Care not Documented**

- **G8338:** Clinician has not documented that communication was sent to the physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

#### **Post-Fracture Care Not Communicated by Reason of Appropriate Exclusion**

**G8339:** Patient was not an eligible candidate for communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

#### **OR**

**Append a modifier (1P or 2P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- 2P: Documentation of patient reason for not communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis with physician managing ongoing care of patient

#### **Denominator**

All patients aged 50 years and older treated for hip, spine or distal radial fracture.

#### **Denominator Coding:**

A Diagnosis Code or Procedure Code to identify patients with a recent fracture of the hip, spine or distal radius is required for denominator inclusion:

- **CPT Codes:** 22305-22328, 22520, 22521, 22523, 22524, 25600-25620, 25685, 27193-27248

#### **AND**

- **ICD-9-CM Codes:** 733.10, 733.11, 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.20, 805.21, 805.22, 805.23, 805.24, 805.25, 805.26, 805.27, 805.28, , 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.03, 820.09, 820.10, 820.11, 820.13, 820.8, 820.9

#### **Rationale**

Patients who experience fragility fractures should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician providing on-going care for the patient be made aware the patient has sustained a non-traumatic fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The

work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

Clinical Recommendation Statements:

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

- BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AGA)

### **\*Measure #25: Melanoma: Patient Medical History**

#### Description

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months

#### Instructions

This is a **patient-specific measure** that is anticipated to be reported a minimum of once within 12 months. It is anticipated that clinicians providing services for the primary treatment or follow-up of cutaneous melanoma will submit this measure.

#### **This measure can be reported using either G-codes OR CPT Category II codes.**

ICD 9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code OR the CPT Category II code WITH the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons, 3P- system reasons.

#### Numerator

Patients who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months.

#### **Numerator Coding:**

#### **Medical History with Review of New or Changing Moles Documented (use one of the following codes)**

- **G8275:** Patient documented to have medical history taken which included assessment of new or changing moles

#### **OR**

- **CPT II 1050F:** History obtained regarding new or changing moles.

#### **Medical History with Review of New or Changing Moles not Documented**

- **G8276:** Patient not documented to have received medical history with assessment of new or changing moles.

#### **Medical History with Review of New or Changing Moles not completed by Reason of Appropriate Exclusion**

- **G8277:** Patient was not an eligible candidate for medical history review with assessment of new or changing moles.

#### **OR**



**Append a modifier (1P or 2P or 3P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not asking about presence of new or changing moles.
- 2P: documentation of patient reason(s) for not asking about presence of new or changing moles.
- 3P: documentation of system reason(s) for not asking about presence of new or changing moles.

Denominator

All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma

**Denominator Coding:**

A Diagnosis Code and Procedure Code to identify patients with either a current diagnosis of melanoma or a history of cutaneous melanoma and seen by the physician should be included.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99382-99384, 99385- 99387, 99392-99394, 99395-99397, 99401-99404

**AND**

**ICD-9-CM Codes:** V10.82, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9

Rationale

While there are not widely available data documenting a gap in care for whether a history was taken, consensus exists among practicing dermatologists that there is room for improvement regarding physicians asking patients about new or changing moles. Early detection of additional primary melanomas is the goal of follow-up care. The majority of recurrences are discovered by the patient or family member.

Clinical Recommendation Statements:

- **American Academy of Dermatology. (2001) Guidelines of Care for Primary Cutaneous Melanoma**
  - The results of routine interval history and physical examination should direct the need for laboratory tests and imaging studies.
- **National Comprehensive Cancer Network (2006) Clinical Practice Guidelines in Oncology: Melanoma**
  - For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated.
  - For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated.

## **\*Measure #26: Melanoma Complete Physical Skin Examination**

### Description

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed at least once within 12 months

### Instructions

This is a **patient-specific measure** that is anticipated to be reported once within 12 months. It is anticipated that patients with either a current diagnosis of melanoma or a history of cutaneous melanoma should receive a complete physical skin exam at least once within 12 months. It is anticipated that clinicians providing primary treatment or follow-up for melanoma will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons, 3P – system reasons

### Numerator

Patients who had a complete physical skin exam performed at least once within 12 months

### **Numerator Coding:**

#### **Complete Physical Skin Exam Documented**

- **G8278:** Patient documented to have received complete physical skin exam
- OR**
- **CPT II 2029F:** Complete physical skin exam performed

#### **Complete Physical Skin Exam not Documented**

- **G8279:** Patient not documented to have received a complete physical skin exam

#### **Complete Physical Skin Exam not Performed by Reason of Appropriate Exclusion**

- **G8280:** Patient was not an eligible candidate for complete physical skin exam during the reporting year
- OR**

**Append a modifier (1P, 2P or 3P) to the following CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not performing a complete physical skin exam

- 2P: documentation of patient reason(s) for not performing a complete physical skin exam
- 3P: documentation of system reason(s) for not performing a complete physical skin exam

#### Denominator

All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma

#### Denominator Coding:

A Diagnosis Code and Procedure Code to identify patients with either a current diagnosis of melanoma or a history of cutaneous melanoma and seen by a physician should be included.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404

#### AND

- **ICD-9-CM Codes:** V10.82, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9

#### Rationale

A complete skin examination should be performed to identify recurrences of melanoma; the genital area may be excluded per patient preference. Published literature suggests that a complete skin exam performed by a physician may result in identification of a second melanoma at an earlier stage, which positively impacts life expectancy and cost effectiveness, when compared with other screening strategies.

#### Clinical Recommendation Statements:

- **American Academy of Dermatology. (2001) Guidelines of Care for Primary Cutaneous Melanoma**
  - Routine interval follow-up physical examinations are recommended at least annually.
- **National Comprehensive Cancer Network (2006) Clinical Practice Guidelines in Oncology: Melanoma**
  - For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated.
  - For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated.

## **\*Measure #27: Melanoma Counseling on Self-Examination**

### Description

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who were counseled at least once within 12 months, to perform a self-examination for new or changing moles

### Instructions

This is a **patient-specific measure** that is anticipated to be reported once within 12 months. It is anticipated that patients with either a current diagnosis of melanoma or a history of cutaneous melanoma should be counseled at least once within 12 months to perform self-examination. It is anticipated that clinicians providing primary treatment or follow-up for melanoma will submit this measure.

### **This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons, 3P – system reasons

### Numerator:

Patients who were counseled at least once within 12 months, to perform self-examination for new or changing moles

### **Numerator Coding:**

#### **Patient Counseling to Perform a Self-Examination Documented**

- **G8281:** Patient documented to have received counseling to perform self-examination
- OR**
- **CPT II 5005F:** Patient counseled on self-examination for new or changing moles

#### **Patient Counseling to Perform a Self-Examination not Documented**

- **G8282:** Patient not documented to have received counseling to perform self-examination.

#### **Patient Counseling to Perform a Self-Examination not Performed by Reason of Appropriate Exclusion**

- **G8283:** Patient was not an eligible candidate for counseling to perform self-examination

**OR**

Append a modifier (1P, 2P or 3P) to the following CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.

- 1P: documentation of medical reason(s) for not counseling patient to perform self-examination for new or changing moles
- 2P: documentation of patient reason(s) for not counseling patient to perform self-examination for new or changing moles
- 3P: documentation of system reason(s) for not counseling patient to perform self-examination for new or changing moles

Denominator:

All patients with either a current diagnosis of melanoma or a history of cutaneous melanoma

**Denominator Coding:**

A Diagnosis Code and Procedure Code to identify patients with either a current diagnosis of melanoma or a history of cutaneous melanoma and seen by a physician should be included.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404

**AND**

- **ICD-9-CM Codes:** V10.82, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9

Rationale

Significant opportunity exists to increase rates of patient self-examination. Educating patients to perform self-examinations will lead to earlier detection of secondary sites of melanoma.

Clinical Recommendation Statements:

- **American Academy of Dermatology. (2001) Guidelines of Care for Primary Cutaneous Melanoma**
  - Patient education on self-examination of the skin and lymph nodes is recommended. (AAD)
- **British Association of Dermatologists. (2002) U.K. guidelines for the management of cutaneous melanoma.**
  - All patients should be taught self-examination because many recurrences are found by patients themselves at home rather than by clinicians in the clinic

#### **\*Measure #28: Emergency Medicine: Aspirin at arrival for acute myocardial infarction (AMI)**

##### Description

Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

##### Instructions

This is a **visit-specific measure** that is anticipated to be reported after discharge from the *emergency department*. It is anticipated that patients who are discharged from the *emergency department* with a diagnosis of AMI would have documentation in the medical record of having received aspirin 24 hours before emergency department arrival or during emergency department stay. Clinicians providing care in the emergency department are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P – patient reasons.

##### Numerator

Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

##### **Numerator Coding:**

**Aspirin received or taken 24 hours before emergency department arrival or during emergency department stay (use one of the following codes)**

- **G8353:** Patient documented to have received or taken aspirin within 24 hours before emergency department arrival or during emergency department stay

##### **OR**

- **CPT II XXXXF:** Aspirin received within 24 hours before emergency department arrival or during emergency department stay

**Aspirin not received or taken 24 hours before emergency department arrival or during emergency department stay**

- **G8354:** Patient not documented to have received or taken aspirin within 24 hours before emergency department arrival or during emergency department stay

**Aspirin not received or taken 24 hours before emergency department arrival or during emergency department stay by reason of appropriate exclusion**

- **G8355:** Clinician documented that patient was not an eligible candidate to receive aspirin

**OR**

**Append a modifier (1P or 2P) to one of the above CPT Category II codes to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay
- 2P: Documentation of patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay

**Denominator:**

All patients with an emergency department discharge diagnosis of acute myocardial infarction

**Denominator Coding:**

Evaluation and Management/Office Visit Codes (CPT) and emergency department discharge diagnosis codes (ICD-9) are required for denominator inclusion to identify patients with a diagnosis of AMI

- **CPT Codes:** 99281, 99282, 99283, 99284, 99285, 99291

**AND**

- **ICD-9 Code:** 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92

**Rationale**

The emergency physician should document that the patient received aspirin no matter where or when the aspirin was taken.

**Clinical Recommendation Statements:**

Aspirin should be chewed by patients who have not taken aspirin before presentation with STEMI. The initial dose should be 162 mg (*Level A*) to 325 mg (*Level C*). Although some trials have used enteric-coated aspirin for initial dosing, more rapid buccal absorption occurs with non-enteric-coated aspirin formulations. (ACC/AHA)

#### **Measure #29: Beta blocker at time of arrival for acute myocardial infarction**

Numerator: Acute myocardial infarction patients who received beta blocker within 24 hours before or after hospital arrival

##### **Numerator coding**

- **G8009:** Acute myocardial infarction: patient documented to have received beta-blocker at arrival
- **G8010:** Acute myocardial infarction: patient not documented to have received beta-blocker at arrival
- **G8011:** Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

##### **Denominator:**

*Patients with acute myocardial infarction who present to hospital emergency department or are hospitalized as listed:*

##### **Denominator coding**

Patients with acute myocardial infarction:

ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

##### **AND**

Initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

##### **Instructions:**

This is a **visit-specific measure** that is anticipated to be reported at each visit. It is anticipated that the patient would receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the emergency department or hospital setting. Thus, it is anticipated that the clinician providing the services in the emergency department or hospital will submit this measure. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.



**\*Measure #30: Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician**

Description

Percentage of surgical patients aged 18 and older who have an order for a parenteral antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who undergo surgical procedures with the indications for prophylactic antibiotics during the reporting period. It is anticipated that anesthesiologists providing anesthesia care for surgical procedures will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients that are included in the denominator; in some instances, CPT II or G-Codes may also be needed to define the denominator. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code
3. Modifiers may not be used –there are no allowable exclusions for this measure

Numerator

Surgical patients for whom administration of a prophylactic antibiotic has been initiated within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

**Numerator Coding:**

**Table 2A: The antimicrobial drugs listed below are considered prophylactic antibiotics for the purposes of this measure.**

• Ampicillin/sulbactam	• Cefoxitin	• Gentamicin
• Aztreonam	• Cefuroxime	• Levofloxacin
• Cefazolin	• Ciprofloxacin	• Metronidazole
• Cefmetazole	• Clindamycin	• Moxifloxacin
• Cefotetan	• Erythromycin base	• Neomycin
	• Gatifloxacin	• Vancomycin

**Prophylactic Antibiotic Given (use one of the following codes)**

- **G8195:** Clinician documented to have given the prophylactic antibiotic within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

**OR**

- **CPT II XXXXF:** Documentation that prophylactic antibiotic was given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**Exclusions**

- None

**Administration of Prophylactic Antibiotic not documented**

- **G8196:** Clinician did not document a prophylactic antibiotic was administered within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**Denominator**

All surgical patients aged 18 years and older who have an order for a parenteral antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

**Denominator Instruction:**

For denominator inclusion, there must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

**Denominator Coding:**

- **G8197:** Patient documented to have order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**OR**

- **CPT II XXXXF:** Documentation of order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

**Rationale**

The appropriate timing of administration of prophylactic antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Available evidence suggests that although most surgical patients receive a prophylactic antibiotic, many do not receive the drug within one hour before incision as recommended.

**Clinical Recommendation Statements:**

The anti-infective drug should ideally be given within 30 minutes to 1 hour before the initial incision to ensure its presence in an adequate concentration in the targeted tissues. For most procedures,

scheduling administration at the time of induction of anesthesia ensures adequate concentrations during the period of potential contamination. Exceptions: cesarean procedures (after cross clamping of the umbilical cord); colonic procedures (starting 19 hours before the scheduled time of surgery). (ASHP)

Infusion of the first antimicrobial dose should begin within 60 min before incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 min before incision to prevent antibiotic-associated reactions. Although research has demonstrated that administration of the antimicrobial at the time of anesthesia induction is safe and results in adequate serum and tissue drug levels at the time of incision, there was no consensus that the infusion must be completed before incision. (SIPGWW)

**\*Measure #31: Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage**

Description

Percentage of patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage who received DVT prophylaxis by end of hospital day two (2)

Instructions

This is a **visit-specific measure** that is anticipated to be reported after a patient has been diagnosed with ischemic stroke or intracranial hemorrhage and has been in the hospital for 2 days or more. Clinicians who care for patients with a diagnosis of stroke or intracranial hemorrhage in the hospital setting are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD 9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons.

**Definition:** For purposes of this measure, DVT prophylaxis can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), intravenous Heparin, low-dose subcutaneous heparin, or intermittent pneumatic compression devices.

Numerator

Patients who received Deep Vein Thrombosis (DVT) prophylaxis by the end of hospital day two (2).

**Numerator Coding:**

**DVT Prophylaxis Received (use one of the following codes)**

- **G8216:** Patient documented to have received DVT prophylaxis by end of hospital day two

**OR**

- **CPT II XXXXF:** Deep vein thrombosis prophylaxis received by end of hospital day 2

**DVT Prophylaxis not Documented**

- **G8217:** Patient not documented to have received DVT prophylaxis by end of hospital day 2

**DVT Prophylaxis Not Received by Reason of Appropriate Exclusion**

- **G8218:** Patient was not an eligible candidate for DVT Prophylaxis by end of hospital day 2, including physician documentation that patient is ambulatory

OR

**Append a modifier (1P or 2P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not receiving DVT Prophylaxis by end of hospital day 2, including physician documentation that patient is ambulatory
- 2P: documentation of patient reason(s) for not receiving DVT Prophylaxis by end of hospital day 2

#### Denominator

All patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage

#### Denominator Coding:

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage is required for denominator inclusion. (Use the listed CPT codes to identify inpatient setting):

- **ICD-9-CM Codes:** 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

**AND** one of the following **CPT visit codes:**

- 99221, 99222, 99223 (initial inpatient) OR 99231, 99232, 99233 (inpatient)

#### Rationale

Patients on bed rest are at high risk for deep vein thrombosis. DVT prevention is important for all patients who have suffered a stroke or an intracranial hemorrhage and may have decreased mobility. The intent of this measure is to assure that adequate DVT prophylaxis is received for either diagnosis. As noted in the clinical recommendation statements, the appropriate *type* of prophylaxis differs by diagnosis. Anticoagulants are generally contraindicated in patients with intracranial hemorrhage. These patients are still at risk for DVT so they should receive prophylaxis with mechanical devices. Low-dose subcutaneous heparin may be initiated on the second day after onset of the hemorrhage.

#### Clinical Recommendation Statements:

Subcutaneous unfractionated heparin, LMW heparins, and heparinoids may be considered for DVT prophylaxis in at-risk patients with acute ischemic stroke, recognizing that nonpharmacologic treatments for DVT prevention also exist. (Coull, AAN/ASA, 2002) (Grade A)

The use of intermittent external compression stockings or aspirin for patients who cannot receive anticoagulants is strongly recommended to prevent deep vein thrombosis among immobilized patients. (Adams, ASA, 2003) (Grades A and B)

For acute stroke patients with restricted mobility, we recommend prophylactic low-dose subcutaneous heparin or low-molecular-weight heparins or heparinoid (Grade 1A). In patients with an acute ICH, we recommend the initial use of intermittent pneumatic compression for the prevention of DVT and PE. (Grade 1C+) In stable patients, we suggest low-dose subcutaneous

heparin may be initiated as soon as the second day after the onset of the hemorrhage. (Grade 2C)  
(Albers, ACCP, 2004)

### **\*Measure #32: Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy**

#### Description

Percentage of patients aged 18 years and older with the diagnosis of *ischemic stroke* or *TIA* who were prescribed antiplatelet therapy at discharge.

#### Instructions

This is a **visit-specific measure** that is anticipated to be reported after a patient has been discharged from the hospital with a diagnosis of ischemic stroke or TIA. Clinicians who care for patients with a diagnosis of stroke or TIA in the hospital setting are responsible for submitting this measure.

#### **This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons

#### Definition:

Antiplatelet therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine

#### Numerator

Patients who were prescribed antiplatelet therapy at discharge

#### Numerator Coding:

##### **Antiplatelet Therapy Prescribed (use one of the following codes)**

- **G8222:** Patient documented to have been prescribed antiplatelet therapy at discharge
- OR**
- **CPT II XXXXF:** Oral antiplatelet therapy prescribed at discharge

##### **Antiplatelet Therapy Prescription not Documented**

- **G8223:** Patient not documented to have received prescription for antiplatelet therapy at discharge

##### **Antiplatelet Therapy Prescription not Received by Reason of Appropriate Exclusion**

- **G8224:** Clinician documented that patient was not an eligible candidate for antiplatelet therapy at discharge, including identification from medical record that patient on anticoagulation therapy
- OR**

**Append a modifier (1P or 2P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not prescribing antiplatelet therapy at discharge, including identification from medical record that patient on anticoagulation therapy
- 2P: documentation of patient reason(s) for not prescribing antiplatelet therapy at discharge

Denominator

All patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA)

**Denominator Coding:**

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA) is required for denominator inclusion. (Use the listed CPT codes to identify inpatient setting):

- **ICD-9-CM Codes:** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

**AND**

**one of the following CPT visit codes:**

- 99218, 99219, 99220 (initial observation care), OR 99221, 99222, 99223 (initial inpatient), OR 99231, 99232, 99233 (inpatient)

Rationale

Following a stroke, patients should be prescribed antiplatelet therapy to decrease the risk of additional strokes.

Clinical Recommendation Statements:

We recommend that every patient who has experienced a noncardioembolic (atherothrombotic, lacunar, or cryptogenic) stroke or TIA and has no contraindication receives an antiplatelet agent regularly to reduce the risk of recurrent stroke and other vascular events. Aspirin, 50 to 325 mg qd; the combination of aspirin, 25 mg, and extended-release dipyridamole, 200 mg bid; or clopidogrel, 75 mg qd, are all acceptable options for initial therapy. (Albers, ACCP, 2001) (Grade 1A)

For patients with noncardioembolic ischemic stroke or TIA, antiplatelet agents rather than oral anticoagulation are recommended to reduce the risk of recurrent stroke and other cardiovascular events. (Sacco, ASA, 2006) (Class I, Level of Evidence: A)

Aspirin (50 to 325 mg/d), the combination of aspirin and extended-release dipyridamole, and clopidogrel are all acceptable options for initial therapy (Sacco, ASA, 2006) (Class IIa, Level of Evidence: A)



**\*Measure #33: Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge**

Description

Percentage of patients aged 18 years and older with the diagnosis of *ischemic stroke* or *TIA* with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

Instructions

This is a **visit-specific measure** that is anticipated to be reported after a patient has been discharged from the hospital with a diagnosis of ischemic stroke or TIA with documented permanent or persistent atrial fibrillation. Clinicians who care for patients with a diagnosis of stroke or TIA in the hospital setting are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons

Definitions:

Persistent Atrial Fibrillation: recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically.

Paroxysmal Atrial Fibrillation: recurrent atrial fibrillation, self-terminating

Permanent Atrial Fibrillation: long-standing atrial fibrillation (>1 year), cardioversion failed or not attempted

Numerator

Patients who were prescribed an anticoagulant at discharge

**Numerator Coding:**

**Anticoagulant Prescribed (use one of the following coding options)**

- **G8225:** Patient documented to have been prescribed an anticoagulant at discharge
- OR**
- **CPT II XXXXF:** Anticoagulant therapy prescribed at discharge
- AND**
- **CPT II XXXXF:** Documentation of permanent OR persistent OR paroxysmal atrial fibrillation

**Anticoagulant Prescription not Documented**

- **G8226:** Patient not documented to have received prescription for anticoagulant therapy at discharge

**Anticoagulant not Prescribed by Reason of Patient Ineligibility**

- **G8227:** Patient not documented to have permanent, persistent, or paroxysmal atrial fibrillation

**OR**

- **CPT II XXXXF:** Documentation of absence of permanent AND persistent AND paroxysmal atrial fibrillation

**Anticoagulant Prescription not Received by Reason of Appropriate Exclusion**

- **G8228:** Clinician documented that patient was not an eligible candidate for anticoagulant therapy at discharge

**OR**

**Append a modifier (1P or 2P) to the CPT Category II code above to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not prescribing anticoagulant therapy at discharge
- 2P: documentation of patient reason(s) for not prescribing anticoagulant therapy at discharge

**Denominator**

All patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation

**Denominator Coding:**

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA) AND atrial fibrillation is required for denominator inclusion. (Use the listed CPT codes to identify inpatient setting):

- **ICD-9-CM Codes:** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

**AND**

**ICD-9-CM code:** 427.31 (atrial fibrillation)

**AND**

- **One of the following CPT visit codes:** 99218, 99219, 99220 (initial observation care), OR 99221, 99222, 99223 (initial inpatient), OR 99231, 99232, 99233 (inpatient)

**Rationale**

Patients with atrial fibrillation (either permanent, persistent, or paroxysmal) and stroke should be prescribed an anticoagulant to prevent recurrent strokes.

**Clinical Recommendation Statements:**

Administer antithrombotic therapy (oral anticoagulation or aspirin) to all patients with AF, except those with lone AF, to prevent thromboembolism. (ACC/AHA/ESC, 2001)(Class I, Level of Evidence: A)

We recommend that clinicians use long-term oral anticoagulation (target INR of 2.5; range, 2.0 to 3.0) for prevention of stroke in atrial fibrillation patients who have suffered a recent stroke or TIA. Oral anticoagulation is also beneficial for prevention of recurrent stroke in patients with several other high-risk cardiac sources. (Albers, ACCP, 2001) (Grade 1A)

For patients with ischemic stroke or TIA with persistent or paroxysmal AF, anticoagulation with adjusted-dose warfarin (target INR, 2.5; range 2.0 to 3.0) is recommended. (Sacco, ASA, 2006) (Class I, Level of Evidence: A)

**\*Measure #34: Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA)  
Considered**

Description

Percentage of patients aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration.

Instructions

This is a **visit-specific measure** that is anticipated to be reported for each patient diagnosed with ischemic stroke. Clinicians who care for patients with a diagnosis of stroke in the hospital setting are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD 9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code
3. Modifiers may not be used – there are no allowable exclusions for this measure

Definition:

For purposes of this measure, patients “considered for t-PA administration” includes patients to whom t-PA was given or patients for whom reasons for not being a candidate for t-PA therapy are documented.

Numerator

Patients who were considered for t-PA administration (given t-PA or documented reasons for patient not being a candidate for therapy)

**Numerator Coding:**

**t-PA Administration or Consideration documented (use one of the following coding options)**

- **G8229:** Patient documented to have been administered or considered for t-PA
- OR**
- **CPT II XXXXF:** Ischemic stroke symptom onset of less than 3 hours to arrival **AND**
  - **CPT II XXXXF:** Documentation that tissue plasminogen activator (t-PA) administration was considered

**t-PA not Administered due to Patient Ineligibility**

- **G8230:** Patient not eligible for t-PA administration, ischemic stroke symptom onset of more than 3 hours
- **CPT II XXXXF:** Ischemic stroke symptom onset greater than or equal to 3 hours prior to arrival

### **t-PA Administration or Consideration not Documented**

- **G8231:** Patient not documented to have received t-PA or not documented to have been considered a candidate for t-PA administration

### **Exclusions**

- None

### Denominator

All patients aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours.

### Denominator Coding:

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke is required for denominator inclusion. (Use the listed CPT codes to identify inpatient setting):

- **ICD-9-CM Codes:** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

### AND

- **One of the following CPT visit codes:** 99218, 99219, 99220 (initial observation care), OR 99281, 99282, 99283, 99284, 99285 (emergency department), OR 99221, 99222, 99223 (initial inpatient)

### Rationale

Patients who arrive at the hospital within 3 hours of stroke symptom onset should be considered for t-PA therapy.

### Clinical Recommendation Statements:

We recommend administration of IV tPA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 min for eligible patients, provided that treatment is initiated within 3 h of clearly defined symptom onset. We recommend strict adherence to eligibility criteria for the use of IV tPA based on the NINDS trial protocol.

(Inclusion Criteria: Age  $\geq$  18 years, clinical diagnosis of stroke with a clinically meaningful neurologic deficit, clearly defined time of onset of  $< 180$  min before treatment, and a baseline CT showing no evidence of intracranial hemorrhage. (Albers, ACCP, 2001) (Grade 1A)

Intravenous rtPA (0.9 mg/kg, maximum dose 90 mg) is strongly recommended for carefully selected patients who can be treated within 3 hours of onset of ischemic stroke. (Adams, ASA, 2003) (Grade A)

### **\*Measure #35: Stroke and Stroke Rehabilitation: Screening for Dysphagia**

#### Description

Percentage of patients aged 18 years and older with the diagnosis of *ischemic stroke* or *intracranial hemorrhage* who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth.

#### Instructions

This is a **visit-specific measure** that is anticipated to be reported for patients with a diagnosis of ischemic stroke or intracranial hemorrhage and were treated in the hospital. Clinicians who care for patients with a diagnosis of stroke or intracranial hemorrhage in the hospital setting are responsible for submitting this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code OR the CPT Category II code WITH the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

#### Definition:

Dysphagia Screening: use of a tested and validated dysphagia screening tool (e.g. Burke dysphagia screening test, 3 oz. water swallow test, Mann assessment of swallowing ability [MASA], standardized bedside swallowing assessment [SSA]) OR a dysphagia screening tool approved by the hospital's speech/language pathology (SLP) services.

#### Numerator

Patients who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

Numerator instruction: For purposes of this measure, patients "who receive any food, fluids or medication by mouth" may be identified by the absence of an NPO (nothing by mouth) order

#### Numerator Coding:

**Dysphagia Screening Conducted (use one of the following coding options)**

- **HCPCS code V5364:** Dysphagia screening

#### AND

- **G8232:** Patient documented to have received dysphagia screening prior to taking any foods, fluids or medication by mouth

#### OR

- **HCPCS code V5364:** Dysphagia screening

**AND**

- **CPT II XXXXF:** Patient receiving or eligible to receive food, fluids or medication by mouth

**AND**

- **CPT II XXXXF:** Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth

**Dysphagia Screening not Documented**

- **G8234:** Patient not documented to have received dysphagia screening

**Patient Ineligible for Dysphagia Screening**

- **G8235:** Patient not receiving or ineligible to receive food, fluids or medication by mouth, or documentation of NPO (nothing by mouth) order

**OR**

- **CPT Cat II XXXXF:** NPO (nothing by mouth) ordered

**Dysphagia Screening not Conducted by Reason of Appropriate Exclusion**

- **G8236:** Clinician documented that patient was not an eligible candidate for dysphagia screening prior to taking any foods, fluids or medication by mouth

**OR**

**Append a modifier (1P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth

**Denominator**

All patients, 18 years and older, with the diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth

**Denominator Coding:**

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage is required for denominator inclusion. (Use the listed CPT codes to identify inpatient setting):

- **ICD-9-CM Codes:** 430, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 432.0, 432.1, 432.9

**AND**

- **One of the following CPT visit codes:** 99218, 99219, 99220 (initial observation care), OR 99281, 99282, 99283, 99284, 99285 (emergency department), OR 99221, 99222, 99223 (initial inpatient)

**Rationale**

All patients should have their swallowing evaluated prior to receiving food, fluids or oral medications to help prevent aspiration. The evaluation should be performed with a validated or hospital-approved dysphagia screening tool; a routine cranial nerve examination is not sufficient.

Clinical Recommendation Statements:

Recommend that all patients have their swallow screened before initiating oral intake of fluids or food, utilizing a simple valid bedside testing protocol. (VA/DoD, 2003) (Evidence II-2, Grade B)



### **\*Measure #36: Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services**

#### Description

Percentage of patients aged 18 years and older with the diagnosis of *ischemic stroke* or *intracranial hemorrhage* for whom consideration of rehabilitation services is documented

#### Instructions

This is a **visit-specific measure** that is anticipated to be reported for patients with a diagnosis of ischemic stroke or intracranial hemorrhage and were treated in the hospital. Clinicians who care for patients with a diagnosis of stroke or intracranial hemorrhage in the hospital setting are responsible for submitting this measure.

#### **This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code
3. Modifiers may not be used – there are no allowable exclusions for this measure

#### Definition:

For purposes of this measure, “consideration of rehabilitation services” includes an order for rehabilitation services or documentation that rehabilitation was not indicated.

#### Numerator

Patients for whom consideration of rehabilitation services (ordered rehabilitation or documented that rehabilitation was not indicated) is documented

#### Numerator Coding:

##### **Rehabilitation Services Ordered or Considered (use one of the following codes)**

- **G8237:** Patient documented to have received order for rehabilitation services or documentation of consideration for rehabilitation services

##### OR

- **CPT II XXXXF:** Documentation that rehabilitation services were considered

##### **Rehabilitation Services Ordered or Considered not Documented**

- **G8238:** Patient not documented to have received order for or consideration for rehabilitation services

#### **Exclusions**

- None

#### Denominator

All patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage

**Denominator Coding:**

A Diagnosis Code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage is required for denominator inclusion (Use the listed CPT codes to identify inpatient setting):

- **ICD-9-CM Codes:** 430, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 432.0, 432.1, 432.9

**AND**

- **One of the following CPT visist codes:** 99221, 99222, 99223 (initial inpatient), OR 99231, 99232, 99233 (inpatient)

**Rationale**

All patients should be considered for rehabilitation services to meet the individual patient needs.

**Clinical Recommendation Statements:**

Strongly recommend that patients in need of rehabilitation services have access to a setting with a coordinated and organized rehabilitation care team that is experienced in providing stroke services. The coordination and organization of inpatient post–acute stroke care will improve patient outcome. (VA/DoD, 2003)

### Measure #37: Dialysis dose in end stage renal disease patient

#### Numerator:

Hemodialysis patient with a URR value of 65% or higher or a Kt/V greater than or equal to 1.2

#### Numerator coding:

- **G8075:** End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)
- **G8076:** End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)
- **G8077:** Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

#### Denominator:

*Patients 18 years of age or older with end-stage renal disease on hemodialysis as listed:*

#### Denominator coding:

**CPT codes:** G0314-G0319, G0322, G0323, G0326, G0327, 90935, 90937

**OR**

**ICD-9-CM codes:** 585.6 (End-stage renal disease)

#### Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. To report this measure use the appropriate quality G-code indicator, the listed ICD-9, and CPT codes when providing care to patients with end stage renal disease on hemodialysis. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

### **Measure #38: Hematocrit level in end stage renal disease patient**

#### Numerator:

Hemodialysis patient with a hematocrit greater than or equal to 33 or a hemoglobin greater than or equal to 11

#### Numerator coding:

- **G8078:** End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)
- **G8079:** End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)
- **G8080:** Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

#### Denominator:

*Patients 18 years of age or older with end-stage renal disease on hemodialysis as listed:*

#### Denominator coding:

**CPT codes:** G0314-G0319, G0322, G0323, G0326, G0327, 90935, 90937

OR

**ICD-9-CM codes:** 585.6 (End-stage renal disease)

#### Instructions:

This is a **patient-specific measure** that is anticipated to be reported a minimum of once per reporting period for patients seen during the reporting period. To report this measure use the appropriate quality G-code indicator, the listed ICD-9, and CPT codes when providing care to patients with end stage renal disease on hemodialysis. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

### **\*Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older**

#### Description

Percentage of female patients aged 65 years and older who have a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.

#### Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that female patients aged 65 years and older will have a central DXA measurement ordered or performed at least once since the time they turned 60 years or have pharmacologic therapy prescribed to prevent or treat osteoporosis. It is anticipated that clinicians providing primary care or care for treatment of fracture or osteoporosis will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons, 3P – system reasons

#### Numerator

Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

**Definitions:** Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

#### Numerator Coding:

**Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed (use one of the following codes)**

- **G8340:** Patient documented to have had central DXA performed and results documented or central DXA ordered or pharmacologic therapy prescribed

**OR**

- **CPT II 3095F:** Central Dual-energy X-Ray Absorptiometry (DXA) results documented

**OR**

- **CPT II 3096F:** Central Dual-energy X-Ray Absorptiometry (DXA) ordered

**OR**

- **CPT II 4005F:** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

**Central DXA Measurement or Pharmacologic Therapy not Documented**

- **G8341:** Patient not documented to have had central DXA measurement or pharmacologic therapy

**Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed by Reason of Appropriate Exclusion**

- **G8342:** Clinician documented that patient was not an eligible candidate for central DXA measurement or prescribing pharmacologic therapy

**OR**

**Append a modifier (1P, 2P or 3P) to one of the above CPT Category II codes to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- 2P: Documentation of patient reason for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- 3P: Documentation of system reason for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis

**Clinician has not Provided Care**

- **G8343:** Clinician has not provided care for the patient for the required time for central DXA measurement or pharmacological therapy measure

**Denominator**

All female patients aged 65 years and older

**Denominator Coding:**

A Procedure Code to identify female patients aged 65 years and older and seen by the physician at least twice within 12 months should be included.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404

**Rationale**

Patients with elevated risk for osteoporosis should have the diagnosis of osteoporosis excluded or be on treatment of osteoporosis.

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. (B Recommendation) (USPSTF)

The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and nonuse of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements. (AACE)

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD testing should be performed on:

- All women aged 65 and older regardless of risk factors.
- Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal, and female).
- Postmenopausal women who present with fractures. (NQF)

The decision to test for BMD should be based on an individual's risk profile. Testing is never indicated unless the results could influence a treatment decision. (NQF)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis. (Level B Evidence). (NQF)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (NQF)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)



#### **Measure #40: Osteoporosis: Management Following Fracture**

##### Description

Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed

##### Instructions

This is a **patient-specific measure** that is anticipated to be reported once per the reporting period. It is anticipated that patients with a fracture of the hip, spine or distal radius will have a central DXA measurement ordered or performed or pharmacologic therapy prescribed. The management (DXA ordered or performed or pharmacologic therapy prescribed) should occur within three months of the initial visit with the reporting physician following the fracture. Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy would automatically meet the intent of this measure. It is anticipated that clinicians who manage the primary or ongoing care for osteoporosis or osteoporosis related fracture(s) will report this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons, 3P – system reasons

##### Numerator:

Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed

**Definitions:** Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

##### **Numerator Coding:**

**Central DXA Measurement Performed or Pharmacologic Therapy Prescribed (use one of the following codes)**

- **G8344:** Patient documented to have had central DXA ordered or performed and results documented or pharmacological therapy prescribed

**OR**

- **CPT II 3095F:** Central dual energy X-ray absorptiometry (DXA) results documented

**OR**

- **CPT II 3096F:** Central dual energy X-ray absorptiometry (DXA) ordered
- OR**
- **CPT II 4005F:** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

**Central DXA Measurement or Pharmacologic Therapy not Documented**

- **G8345:** Patient not documented to have had central DXA measurement ordered or performed or pharmacologic therapy

**Central DXA Measurement not Performed or Pharmacologic Therapy not Prescribed by Reason of Appropriate Exclusion**

- **G8346:** Clinician documented that patient was not an eligible candidate for central DXA measurement or pharmacologic therapy

**OR**

**Append a modifier (1P, 2P or 3P) to one of the above CPT Category II codes to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- 2P: Documentation of patient reason for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- 3P: Documentation of system reason for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis

**Clinician has not Provided Care**

- **G8347:** Clinician has not provided care for the patient for the required time for central DXA measurement or pharmacological therapy measure

Denominator:

All patients aged 50 years and older with a fracture of the hip, spine or distal radius

**Denominator Coding:**

A Procedure Code to identify patients seen by the physician at least twice within 12 months should be included.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404

A Diagnosis Code or Procedure Code to identify patients with a recent fracture of the hip, spine or distal radius is required for denominator inclusion

- **CPT Codes:** 22305-22328, 22520, 22521, 22523, 22524, 25600-25620, 25685, 27193-27248

**AND**

- **ICD-9-CM Codes:** 733.10, 733.11, 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.20, 805.21, 805.22, 805.23, 805.24, 805.25, 805.26, 805.27, 805.28, 805.29, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.03, 820.09, 820.10, 820.11, 820.13, 820.8, 820.9

#### Rationale

Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fracture occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

#### Clinical Recommendation Statements:

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

#### **\*Measure #41: Osteoporosis: Pharmacologic Therapy**

##### Description

Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

##### Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the measurement period. It is anticipated that patients with a diagnosis of osteoporosis will be prescribed a pharmacologic therapy to treat osteoporosis. It is anticipated that clinicians providing services for patients with the diagnosis of osteoporosis will submit this measure.

##### **This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier codes allowed for this measure are: modifier 1P- medical reasons, 2P- patient reasons, 3P – system reasons

##### Numerator:

Patients who were prescribed pharmacologic therapy within 12 months

**Definitions:** Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

##### **Numerator Coding:**

###### **Pharmacologic Therapy Prescribed**

- **G8284:** Patients documented to have received a prescription for pharmacologic therapy for osteoporosis

###### **OR**

- **CPT II 4005F:** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

###### **Pharmacologic Therapy not Documented**

- **G8285:** Patient not documented to have received pharmacologic therapy

###### **Pharmacologic Therapy not Prescribed by Reason of Appropriate Exclusion**

- **G8286:** Clinician documented that patient was not an eligible candidate for pharmacologic therapy

**OR**

**Append a modifier (1P, 2P or 3P) to one of the above CPT Category II codes to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason for not prescribing pharmacologic therapy for osteoporosis
- 2P: Documentation of patient reason for not prescribing pharmacologic therapy for osteoporosis
- 3P: Documentation of system reason for not prescribing pharmacologic therapy for osteoporosis

**Clinician has not Provided Care**

- **G8287:** Clinician has not provided care for the patient for the required time for the pharmacologic therapy measure

Denominator:

All patients aged 50 years and older with the diagnosis of osteoporosis

**Denominator Coding:**

A Diagnosis Code to identify patients with osteoporosis is required for denominator inclusion

- **ICD-9-CM Codes:** 733.00, 733.01, 733.02, 733.03, 733.09, V17.81

Rationale

Pharmacologic therapy is an evidence-based recommendation for the treatment of osteoporosis.

Clinical Recommendation Statements:

Agents approved by the FDA for osteoporosis prevention and/or treatment include (in alphabetical order) bisphosphonates (alendronate, ibandronate, risedronate), salmon calcitonin, estrogen, raloxifene, and teriparatide. All act by reducing bone resorption, except for teriparatide, which has anabolic effects on bone. Although estrogen is not approved for treatment of osteoporosis, there is level 1 evidence for its efficacy in reducing vertebral fractures, nonvertebral fractures, and hip fractures. Level 1 evidence of efficacy in reducing the risk of vertebral fractures is available for all the agents approved for treatment of osteoporosis (bisphosphonates, calcitonin, raloxifene, and teriparatide). Prospective trials have demonstrated the effectiveness of bisphosphonates and teriparatide in reducing the risk of nonvertebral fractures (level 1), but only bisphosphonates have been shown to reduce the risk of hip fractures in prospective controlled trials (level 1). (AACE)

US Food and Drug Administration-approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, alendronate plus D, ibandronate, and risedronate, risedronate with 500 mg of calcium as the carbonate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid

hormone [PTH (1-34), teriparatide], and selective estrogen receptor modulators or SERMS (raloxifene). (NQF)

#### **\*Measure #42: Osteoporosis: Counseling for Vitamin D and Calcium Intake and Exercise**

##### Description

Percentage of patients, regardless of age, with a diagnosis of osteoporosis who are either receiving both calcium and vitamin D or have been counseled regarding both calcium and vitamin D intake, and exercise at least once within 12 months

##### Instructions

This is a **patient-specific measure** that is anticipated to be reported once during the reporting period. It is anticipated that patients with a diagnosis of osteoporosis will be receiving both calcium and vitamin D or had counseling regarding their use and counseled on exercise. It is anticipated that clinicians providing services for patients with the diagnosis of osteoporosis will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to determine patients that are included in the measure. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P- medical reasons

##### Numerator:

Patients who are either receiving both calcium and vitamin D or have been counseled for both calcium and vitamin D intake, and exercise at least once within 12 months

##### **Numerator Coding:**

##### **Calcium and Vitamin D Received or Counseling Regarding Use, and Exercise**

- **G8288:** Patient documented to have received calcium and vitamin D or counseling on both calcium and vitamin D use, and exercise

##### **OR**

- **CPT II 4019F:** Documentation of receipt of counseling on exercise AND either both calcium and vitamin D use or counseling regarding both calcium and vitamin D use

##### **Calcium and Vitamin D Use or Counseling Regarding Use, and Exercise not Documented**

- **G8289:** Patients with no documentation of calcium and vitamin D use or counseling regarding both calcium and vitamin D use, or exercise

##### **Calcium and Vitamin D not Received or no Counseling Regarding Calcium, Vitamin D Use, and Exercise by Reason of Appropriate Exclusion (e.g. patient has documentation of dementia and is unable to receive counseling)**

- **G8290:** Clinician documentation that patient was not an eligible candidate for calcium and vitamin D, and exercise



**OR**

**Append a modifier (1P) to the above CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**

- 1P: Documentation of medical reason(s) for patient not receiving both calcium and vitamin D or and not needing counseling regarding both calcium and vitamin D intake, and exercise (e.g., patient has dementia and is unable to receive counseling)

**Clinician has not Provided Care**

- **G8291:** Clinician has not provided care for the patient for the required time for the calcium, vitamin D, and exercise measure

**Denominator:**

All patients, regardless of age, with the diagnosis of osteoporosis

**Denominator Coding:**

A Procedure Code to identify patients seen by the physician at least twice within 12 months should be included.

- **CPT Codes:** 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404

A Diagnosis Code to identify patients with osteoporosis is required for denominator inclusion

- **ICD-9-CM Codes:** 733.00, 733.01, 733.02, 733.03, 733.09, V17.81

**Rationale**

Vitamin D and calcium and exercise are important in the treatment of osteoporosis.

**Clinical Recommendation Statements**

Promote a diet with adequate calcium content (500 to 1,000 mg/day). Promote adequate vitamin D intake (at least 400 IU/day; as much as 800 IU/day in the elderly). (AACE)

Advocate regular weight-bearing exercise. Minimize risk of falls and injuries with gait and balance training. (AACE)

Advise all patients to obtain an adequate intake of dietary calcium (at least 1200 mg per day, including supplements if necessary) and vitamin D (400 to 800 IU per day for individuals at risk of deficiency). (NQF)

Advise patients to engage in weight-bearing and muscle-strengthening exercise reduce the risk of falls and fractures. (NQF)

Supplementation with both calcium and vitamin D (plain or activated form) should be required for glucocorticoid-treated patients. (ACR)

All patients require education regarding the importance of lifestyle changes (e.g., regular exercise, smoking cessation) as well as vitamin D and calcium supplementation. (Level D Evidence) (ACR)

All patients require education regarding Vitamin D and calcium supplementation. (AGA)

All patients should receive education on the importance of lifestyle changes (e.g., engaging in regular weight-bearing exercise, quitting smoking, avoiding excessive alcohol intake). (Level D Evidence) (AGA)

**Measure #43: Use of internal mammary artery (IMA) in coronary artery bypass graft surgery (CABG)**

Numerator

Patient who received an IMA coronary artery bypass graft

**Numerator coding:**

- **G8158:** Patient documented to have received coronary artery bypass graft with use of internal mammary artery
- **G8159:** Patient documented to have received coronary artery bypass graft without use of internal mammary artery
- **G8160:** Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure

Denominator:

*Patients with coronary artery bypass graft:*

**Denominator coding:**

**CPT codes:** 33511, 33512, 33533, 33534, 33535

Instructions:

This is a **visit-specific measure** that is anticipated to be reported at each visit. To report this measure use the appropriate quality G-code indicator and the listed CPT codes when providing care for a patient undergoing coronary artery bypass graft surgery. This measure is intended to reflect the quality of the surgical services provided for CABG patients. This measure does not include patients undergoing a repeat coronary artery bypass graft surgery. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure.

**Measure #44: Pre-operative beta-blocker for patient with isolated coronary artery bypass graft (CABG)**

Numerator

Patients undergoing CABG with documented pre-operative beta blockade

**Numerator coding:**

- **G8161:** Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade
- **G8162:** Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade
- **G8163:** Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure

Denominator:

*Patients with* Coronary artery bypass graft:

**Denominator coding:**

**CPT codes:** 33510, 33511, 33512, 33533, 33534, 33535

Instructions:

This is a **visit-specific measure** that is anticipated to be reported at each visit. This measure should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery. The time frame for this measure includes the entire 24 hour period before the incision time. Note: not eligible is considered as, but not limited to, matters such as clinical and patient reasons for not participating in the measure

#### **Measure #45: Perioperative: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)**

##### Description

Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time.

##### Instructions

This is a **procedure-specific measure** that is anticipated to be reported for each procedure for patients who underwent procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic. It is anticipated that surgeons providing the surgical procedures will submit this measure.

**This measure can be reported using either G-codes OR CPT Category II codes.**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients that are included in the denominator; in some instances, CPT II or G-Codes may also be needed to define the denominator. G-codes or CPT Category II are used to report the numerator of the measure.

1. If reporting G-codes submit the appropriate G-code indicator, the listed ICD-9, and E&M service codes.
2. If reporting CPT Category II codes submit the listed ICD-9, E&M service codes, and appropriate CPT Category II code **OR** the CPT Category II code **WITH** the exclusion modifier code. The exclusion modifier code allowed for this measure is: modifier 1P-medical reasons.

##### Numerator:

Cardiac surgical patients who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time

##### Numerator Instruction:

There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 48 hours of surgical end time **OR** documentation that prophylactic antibiotic was discontinued within 48 hours of surgical end time.

##### Numerator Coding:

**Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 48 hours of surgical end time**

- **G8207:** Clinician documented an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time

##### **AND**

- **G8211:** Clinician documented that prophylactic antibiotic was given

##### **OR**

- **CPT II XXXXF:** Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time

**AND**

**CPTII XXXXF:** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

**Documentation that prophylactic antibiotics were discontinued**

- **G8208:** Clinician documented that prophylactic antibiotics were discontinued within 48 hours of surgical end time

Note: A single CPT Category II code may be provided for documentation that antibiotic discontinuation ordered or that antibiotic discontinuation accomplished. Report CPT Category II code above if antibiotics were discontinued within 24 hours.

**Order for Discontinuation of prophylactic antibiotics not documented**

- **G8209:** Clinician did not document an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time

**Prophylactic Antibiotics not Discontinued by Reason of Patient Exclusion**

**G8210:** Clinician documented patient was not an eligible candidate for discontinuation of prophylactic antibiotic discontinuation within 48 hours of surgical end time

**OR**

- **CPT II XXXXF:** Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

**OR**

- **Append a modifier (1P) to a CPT Category II code to report patients with documented circumstances that meet the denominator exclusion criteria.**
  - 1P: documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time

**Denominator:**

All cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic

Denominator instruction: For the purpose of this measure of antibiotic discontinuation, patients may be counted as having “received a prophylactic antibiotic” if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.

**Denominator Coding:**

Cardiac surgical procedure codes for which prophylactic antibiotic is indicated for denominator inclusion

<b>Surgical Procedure</b>	<b>CPT CODE</b>
<b>Cardiothoracic Surgery</b>	33120, 33130, 33140-33141, 33200-33201, 33245-33246, 33250-33251, 33253, 33261, 33300, 33305, 33310, 33315, 33320-33322, 33332, 33335, 33400-33401, 33403-33406, 33410, 33411, 33413, 33416, 33422, 33425-

	33427, 33430, 33460, 33463-33465, 33475, 33496, 33510-33519, 33521-33523, 33530, 33533-33536, 33542, 33545, 33548, 33572, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35820
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#### Rationale

There is no evidence there is added benefit of prolonged prophylactic antibiotic use. Prolonged use may increase antibiotic resistant organisms.

#### Clinical Recommendation Statements

At a minimum, antimicrobial coverage must be provided from the time of incision to closure of the incision. For most procedures, the duration of antimicrobial prophylaxis should be 24 hours or less, with the exception of cardiothoracic procedures (up to 72 hours' duration) and ophthalmic procedures (duration not clearly established). (ASHP)

There is evidence indicating that antibiotic prophylaxis of 48 hours duration is effective. There is some evidence that single-dose prophylaxis or 24-hour prophylaxis may be as effective as 48-hour prophylaxis, but additional studies are necessary before confirming the effectiveness of prophylaxis lasting less than 48 hours. There is no evidence that prophylaxis administered for longer than 48 hours is more effective than a 48-hour regimen. Optimal practice: Antibiotic prophylaxis is not continued for more than 48 hours postoperatively. (STS) (Class IIa, Level B)

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